# GENDER DIFFERENCES IN DEPRESSION, ANXIETY, STRESS, SUICIDAL IDEATION AND SUICIDAL BEHAVIOR, AMONG YOUTH

**This dissertation is submitted for the partial fulfillment for the degree of**

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*Work under supervision of*

**Prof.ANINDITA MUKHERJEE**

**Head of the department**

**Department of Psychology**

**Sister Nivedita University**

*Submitted by*

**SHRAYASEE MITRA**

**M.SC Student**

**Department of Psychology**

**Sister Nivedita University**

Examined
Kasturi Dhara.
5/5/25.

## CERTIFICATE

*This is to certify that the dissertation entitled "Gender Differences in Depression, Anxiety, Stress, Suicidal Ideation and Suicidal Behavior, among Youth", submitted by Miss Shrayasee Mitra, a 4th semester M.Sc student in applied psychology (specialization in clinical psychology), Sister Nivedita University, is a bonafied work, which may be placed before the board of examiners for their evaluation. This is in partial fulfillment for the Degree of M.Sc in applied psychology (specialization in clinical psychology), Sister Nivedita University.*

*This is an original study done by the candidate and has not been submitted by her before in any form for any other degree of this University or any other University.*

30-4-25

**Anindita Mukherjee**

**Head of the Department**

**Department of Applied Psychology**

**Sister Nivedita University**

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Shrayasee Mitra. 30. 4. 25

**Shrayasee Mitra**

**(Department of Psychology, Sister Nivedita University)**

# PLAGIARISM DECLARATION

**"I, SHRAYASEE MITRA, hereby declare that the research work titled,"Gender Differences in Depression, Anxiety, Stress , Suicidal Ideation and Suicidal Behaviour, Among Youth", conducted by me, has been completed with full honesty and integrity. I confirm that the work is original and all sources of information have been appropriately acknowledged and cited. Furthermore, I affirm that the research work has undergone thorough plagiarism checks to ensure its authenticity. I take full responsibility for the content and findings presented in this research."**

**Signature:** Shrayasee Mitra
30.4.25

**Name: SHRAYASEE MITRA**

**Enrollment ID: 2322230002078**

**Program and semester: M.SC in Applied Psychology (Specialization Clinical Psychology)**

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# CONTENTS

**Chapter I** **Page No.**

**INTRODUCTION……. 6 - 18**

**Chapter II**

**REVIEW OF LITERATURE…….. 19- 38**

**Chapter III**

**METHODOLOGY……. 39 - 53**

**Chapter IV**

**RESULTS…… 54 - 63**

**Chapter V**

**DISCUSSION…… 64 - 76**

**Chapter VI**

**CONCLUDING REMARKS…… 77 - 82**

**Chapter VII**

**REFERENCES…….. 83 - 92**

**Chapter VIII**

**APPENDICES……. 91 -98**

# Chapter I

# INTRODUCTION

# INTRODUCTION

The World Health Organization (WHO) defined Mental Health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

Mental health is about how we think,feel,act and handle life's challenges. It affects how we deal with stress, relate to others, and make choices every day like our physical health, our mental health is important for living a happy and balanced life. When someone mental health is not in a good place, they may feel overwhelmed, sad, or anxious a lot of the time and it can become harder to cope with things that usually didn't feel so hard. These feelings can be caused by different things like difficult life events, pressure from school or work, or even how we see ourselves. On the other hand , Everyone can face tough moments in life and it's okay to ask for help when needed. Look after ones mental health is as important as taking care of our bodies. Mental health plays a important role in overall well-being of the people in all the stages of life,especially during young adulthood, a period characterized by significant transitions and developmental changes. Youth face various challenges, including academic pressures, career decisions, relationship struggles and personal identity formation. These challenges can sometimes become overwhelming, leading to mental health concerns such as depression, anxiety, stress, and even suicidal thoughts.

**Mental Health and Youth**

Mental health in youth refers to the emotional, psychological and social well being of individuals typically aged 15 to 24 years which influences how people feel and think, behave, build relationships and make decisions,affecting their ability to cope with stress, .Youth mental health is an increasingly important issue, as youth individual face a unique set of challenges that can significantly impact their well-being. Anxiety, depression and eating disorders are among the most common mental health issues that affect youth, because of the academic pressures, the need to fit in, or negative influences from social media. The comparison to idealized images in online, couples with the fear of missing out or being judged, can lead to feelings of inadequacy and isolation. Furthermore, many young people may not feel comfortable to discuss their mental health struggles due to societal stigma, making it difficult for them to seek the

help they need. On the other hand, mental health awareness and programme are growing, to access mental health services remains a challenge in many areas, mainly in suburban or rural areas. It is important to create suitable environment for youth to feel safe to express their emotions, seek support, and learn healthy coping strategies. Education, and open communication, can help youth build resilience and foster better mental well being, ensuring they have the tools to thrive in a challenging world.

Depression, anxiety and stress, suicide are some of the most concerning variables which affects mental health of youth . Suicide is a tragic condition of individual with severe mental distress, while depression, anxiety and stress act here as precursors factors. Understanding these above variables is crucial for developing effective prevention strategies and intervention strategies. Suicide is a worldwide problem, with approximately 800,000 people dying by suicide each year (World Health Organization, 2014). It is the second leading cause of death of the age group 15 - 29 years. It is mentioned that the number of people who attempt suicide is 20 times higher than those who die by suicide (World Health Organization, 2014).

**Suicide**

Suicidal behavior is a major public health priority and major problem in today's world. For almost so many decades, suicide remains one of the leading causes of death globally. Suicide are not only loss of life, but the mental, physical and emotional stress and loss of family members and friends. The individual who attempt suicide need to give them support and require help from health care, psychiatric institutes. It has complex nature, involves biological, genetic and environmental risk factors. Socio cultural and political factors are also crucial to the understanding cause of suicide. Suicide is defined as an act of intentionally terminating one's own life. However, this definition does not do justice to the complexity of the concept and the numerous usages of terms across studies. Thus the nomenclature for suicidal ideation and behavior has been the subject of considerable international attention and debate. Sometimes they are referred to as "suicidality" while others term use as "suicidal behavior" or "suicide related behaviors" .A suicide attempt must have describe the following characteristics: (a) self-initiated, potentially injurious behavior; (b) presence of intent to die; and (c) nonfatal outcome.

On the other hand, Other related behaviors and definitions relevant to this review include deliberate self-harm (DSH), non-suicidal self injury (NSSI), suicidal threats and suicidal gestures. There is also some value in separating out near lethal or medically serious suicide attempt (MSSA) from the non-medically serious suicide attempt (NMSSA).

**Definitions of Suicide:**

The definition of suicide or the act of suicide given by various relevant systems , Suicide defined as " the act of deliberate killing of oneself ".

The WHO (1968) defines suicidal act as "the injury with varying degree of lethal intent", and that suicide may be defined as "a suicidal act with fatal outcome"; and the suicidal acts with non-fatal outcomes are labeled as "attempted suicide".

The word "Suicide" come from the Latin word, which means to "to kill oneself".

The word Suicide was first used by **Sir Thomas Browne** in his "Religio Medici" in 1642 and with by Walter in 1651. Prior to the introduction of word "Suicide" - self-destruction,self-killing and self-murder were in practice.

Suicidal ideation refers to thoughts about death, self-harm, or suicide, which can vary in intensity (how strong or severe the thoughts are) and frequency (how often they occur). Some individuals experience passive thoughts, while others may have persistent and detailed plans for suicide.

The National Crime Records Bureau (NCRB) defines suicide as the "intentional ending of life". It further states that a suicide must have the following characteristics:

1.It should bean unnatural death.

2.Desire to die should origin within

3.There should be a cause to end

Under the Indian Penal Code (IPC), 'Attempted Suicide' is an offence punishable under Sec. 309, as a breach of Art of the Indian Constitution, that guarantees protection of life and personal liberty. Sec 309 reads thus:"Whoever attempts to commit suicide and does any act towards the commission of such offence shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both."

**Lethality in suicide:**

Lethality refers to as the degree of danger to life resulting from a self injurious behaviour and the lethality in suicide define as medical severity of suicidal act, which is very important parameter to assess of the patients who have self harm themselves and how serious the attempt is and what level of intervention needed. The methods which indicates the higher lethality these firearms found to be most higher lethality method ,drowning hanging, jumping, drug/liquid poisoning have a higher chance of death or hospitalization and lower lethality methods are overdosing medicine or any of the self harm behaviour. Lethality is important factor to suicidal risk assessment, Those individual who choose higher lethal method are more prone to intent to die. However, lower lethal method of suicidal attempts are also serious as those attempts denotes emotional distress and have higher risk of future attempts.

Moreover, those contemporary theoretical models of suicidal behaviour and suicidal ideation explain that there is the complex interaction between biological, psychological,environmental and societal factors. This brings problem not only for the patients but also for the clinicians or the other researcher.

**Theoretical models of suicidal behaviour:**

One of the most impactful theory in suicide is **the interpersonal theory of suicidal behaviour** which was proposed by **Van Orden in 2010.** In there the assumptions of suicidal behaviour is stated that the suicidal thoughts are arises when the feeling of burden on others or the feelings that the individual do not belong are perceived as high. The capability of suicide defined as a reduced fear of death and increase the tolerance of pain and In individual when the capability of suicide is present that transform into the suicidal thoughts to suicide attempts.

The **Motivational Volitional Model of Suicidal behaviour** stated by O'Conner in 2011 and later model redefined by O'Conner and Kirtley in 2018 which explain that how suicidal thoughts are arise or develop and they progress into suicidal actions. The model consist of three phases these are pre motivational phase ,motivational phase and volitional phase. This model is denoted as predominent model which was stated that suicidal behaviour is the result of the complex interrelation between the motivational and volitional phase.Those factors with the motivationl phase explain that how the suicidal thoughts emerge in individuals , those factors in motivational phase includes defeat,lack of social support,entrapment and in volitional phase those

factors that transform the suicidal thinking into suicidal behaviour these include fearlessness about death ,exposure to suicide and impulsivity.The entrapment is defined as the feeling of being trapped in the unbearable situation with no way to escape which can cause distress and a key role in development of suicidal thoughts/ ideation.

**Baumeister,s Escape Theory** of Suicide published in 1990 which explain that suicide is a way for people to escape from the negative emotions, feeling of worthlessness, self criticism, deep sense of failure and sense of inadequacy. This theory describe that individual who attempt suicide are often experience distress and feeling of inadequacy which caused by societal and environmental pressure, fails to meet the expectations or goal. The individual feel they are trapped in negative thoughts and believe which unable them to meet the standards which was set by themselves or others which lead them seek relieve by mentally withdrawing from reality, and in severe cases suicide is consider as the final escape from suffering. This process follows a patterns which begin with a individual facing negative situations or failure which lead to self blame and self criticism which creates distress making the individual flee from their negative thoughts or making a individual disconnected from reality.This theory play a significant role because it describe the role of self perception and emotional pain in suicidal behaviour and to prevent suicide surrounding people need to take action and help to consult the mental health professionals who focus on helping and develop self compassion , realistic expectations and healthy coping mechanisms to manage distress to those who had prone to suicidal ideation and behaviour by addressing the issues can reduce the suicidal risk and promote mental well being.

In the youth group, the occurrence of suicidal ideation , behaviour and suicidal attempts or deliberate self harm increases day by day where the suicidal behaviour are influenced by the external and internal factors like low coping mechanism, dependency in phone, increase in media exposure, improper lifestyle, low interaction with family members, sexual abuse, harassment, bullying, teasing and other societal problems. Moreover the risk of suicide also influence by the individual attitude towards problems and how they see the problems and personality factor such as hostility, impulsivity,depression while some of the cases anti social symptoms and depression often arises at the young age.

**Depression, Anxiety, and Stress:**

The **Depression** is mental health condition which caused by persistent feeling of sadness, loss of interest in the activities that are enjoyable before and affects the people how they think, feel, acts. The depression is also classified as a mood disorder which cause difficulty in thinking ,memory,appetite, sleep. On the other hand, **Anxiety** is defined as an emotion characterized by feelings of tension, worry, restlessness and unpleasant state of inner turmoil which is the anticipation of the future one can lead to physical changes and nervous behaviour. Anxiety has also been defined as a vague, uncomfortable feeling exacerbated by prolonged stress and the presence of multiple stressors (Lazarus & Folkman, 1984). The **Stress** is defined as the non specific response of the body to any demand for change. (Hans selye,1936). Stress is the long or short term response of the body which cause distress, tension or physical ,emotional strain.There is two main types of stress- Acute, chronic ,eustress, episodic stress. Depression, anxiety,stress are correlated with each other which is the common disorder globally.The word anxiety comes from the word “angere” which means distress. There is the different anxiety disorder such as generalized anxiety disorder, obsessive compulsive disorder, social anxiety,phobic anxiety disorder. There are two types of anxiety state anxiety defined as the emotional state of individual in response to a particular situation that includes symptoms of tension, apprehension and activation of ANS can also cause tremors,sweating and increased heart rate and blood pressure. Another type is trait anxiety which defined as the tendency of an individual to response to stress with state anxiety.

The **etiology of anxiety** is multifactorial in nature and complex interplay between biological,psychological and societal factors. Biological factor stated that anxiety is correlated with genetic predisposition which tend to run in families,act as a hereditary component. While the previous studies indicates that the heriability rate is approximately 30 to 40%, along with the imbalance in neurotransmitter particularly serotonin, norepinephrine, gamma-aminobutyric acid (GABA), dopamine which regulate mood arousal can contribute to heightened anxiety. When dysregulation in HPA axis which enhanced the activity in brain region particularly in amygdala and prefrontal cortex which contribute in increase fear and threat perception.

Psychological factors like early life experiences,personality traits, cognitive vulnerabilities play a crucial role, others factors like catastrophizing, hypervigilance and those personality factors like high introversion, neuroticism, low self efficacy can contribute to developing anxiety disorder with predisposition of any stressors. Early life experiences like childhood trauma, loss of love ones, neglect can enhance the vulnerability to developing anxiety disorder. Societal factors play a significant role like stressful life event,family and cultural influence, socioeconomic status can contribute to chance of developing the anxiety disorder also in contrast with chronic stress, family conflict,academic and occupational pressure, financial problems, lack of social support influence, moreover unrealistic expectations and stigma may cause anxiety symptoms.

The **etiology of stress** is the complex physiological and psychological response to the body to meet any internal or external demands that's perceive as threatening and challenging, all the biological,psychological, environmental and social factors play a significant role where in biological factors some individual may have genetic vulnerability to predisposed which heightened the stress response to perceived a threats, primarily mediated by the activation of hypothalamic pituitary adrenal (HPA) axis and sympathetic adrenal medullary system (SAM) which leads to release of hormones such as cortisol and adrenaline. If the stress, anxiety,depression run into their family they might be more prone to developing it. Neurochemical imbalance like serotonin,dopamine, norepinephrine and individual differences in physiological reactivity can influence to developing stress. Psychological factor play a significant role the factors which vulnerable to stress include perceptions of control, coping style,personality traits (e.g neuroticism,low self esteem,perfectionism) and harsh life experiences or trauma. Social factors like any major changes in like (divorce, death love one , job loss ), difficulty in interpersonal relationship,work pressure,academic pressure,financial hardship, responsibilities, facing any harsh life experiences, exposure to violence,lack of support can also contribute to heightened the stress level in individual.

Depression is a persistent feeling of sadness and loss of interest in things which affect individual behaviour ,thought,feelings and overall well being.Depressive disorder has 30% increase the risk of suicide and which can comorbidity with other disorder like anxiety disorder,post traumatic stress disorder etc. Depression,anxiety,stress are highly correlated with each other. Symptoms of depression are feeling of emptiness, sadness,hopelessness, guilt, worthlessness, frequent episodes of crying, worry, loss of interest in activities, disturbances in sleeping,low energy,irritability,difficulty managing time and normal work, difficulty fulfilling social expectations.Some people find it difficult to explain this feelings into words.Depression can also cause headaches, chronic body aches. It can also effect of some neurological diseases such as Alzheimer's disease, epilepsy and multiple sclerosis. In severe cases symptoms and factors are associated with suicide. In the several previous studies stated that the motives behind suicide are strain family relationship,love affairs, unhappy marriages , financial issues. According to World Health Organization (WHO) reported that the poverty is the major precipitating factor for suicide which can also cause by stress,mental illness,unemployment,substance abuse.

It is reported that over the 90% individual who died by suicide have mental health disorders (Bertolote & Fleischmann, 2002). In the developing countries,the disorders often strongly predict a suicide attempt are bipolar disorder,PTSD and major depression, conduct disorder and drug abuse (Nock et al.,2009). Results of Autopsy report stated that more than 90 percentage of people who died by suicide have history of mental disorder. The risk of nonfatal suicidal behaviour is increased in youth particularly women although men are more likely to die by suicide. People who are unmarried ,low income group are more to developing suicidal ideation and behaviour.

The **etiology of depression** is **complex** interplay between biological, psychological and social factors which is multidimensional in nature. Biologically,depression has been linked to the genetic predisposition, with hereditary estimate rate approximately 30 to 40 % and imbalance in neurotransmitter such as serotonin, norepinephrine and dopamine. Dysregulation in HPA axis and functional , structural changes in brain regions like hippocampus, prefrontal cortex, amygdala have been cause to depression.

Psychological factors such as negative thought pattern, maladaptive personality traits, low self esteem, early life experiences such as abuse, neglect,loss which can effect emotional processing and coping mechanism.

Social and environmental factors play a significant role , factors which includes are interpersonal conflicts, social isolation, unemployment, financial hardship, chronic stress, and lack of social support can increase the vulnerability to depression. The diathesis-stress model is use to describe that how underlying vulnerabilities interact with stressful life events to trigger depressive episodes. Moreover, enviromental and social factors such as stigma and gender roles, may shape the expression and prevalence of depressive symptoms.

The **biopsychosocial model** explain the multidimensional perspective in understanding the interconnection between depression, anxiety, and stress. In depression, biological factors includes genetic vulnerability and imbalance in neurotransmitter like serotonin and dopamine, interact with psychological elements like negative cognitive schema, low self-esteem, and learned helplessness. Social factors such lack of support, and harsh life experiences, are influence in developing depressive symptoms. In contrast, anxiety disorders are more strongly associated with hyperactivity in brain regions particularly in amygdala and heightened autonomic responses, often influence by genetic predispositions and dysregulation of the HPA axis. Psychologically, anxiety is shaped by cognitive distortions, increase threat perception, and avoidance behaviors, and socially, factors such as high-performance pressure, interpersonal difficulties, and lack of safety contribute significantly. Stress, is overlapping with both conditions, primarily arises from environmental demands exceeding an individual's coping capacity. Biological stress responses increase cortisol levels and sympathetic nervous system activation. Stress is influenced by individual appraisal, coping style, and resilience, whereas social stressors include work overload, interpersonal issues, financial hardship, and social expectations. This model explain that people possess underlying vulnerabilities (diatheses), such as genetic predispositions, neurobiological abnormalities, or life trauma, which may not manifest clinically until triggered by acute or chronic stressors. Depression, anxiety, and stress are interrelated with each other, These conditions often comorbid and reinforce one another, creating burden on the individual's emotional and cognitive processing. Long time exposure to stress can dysregylate HPA axis, increase the chance of anxiety and depressive symptoms. This complex interplay increases the risk of suicidal ideation and suicidal behaviour particularly when individuals perceive threats and incapable to manage and lack adequate coping mechanisms or social

support. The feeling of worthlessness, hopelessness are the cognitive component of depression, combined with the emotional dysregulation from anxiety and the overwhelming burden of stress, increase the risk of suicide. Thus, understanding this model can comprehend assessment and early intervention that targets multiple domains of distress simultaneously, rather than treating each condition.

The management of stress, depression, and anxiety need a multidisciplinary approach that focus on pharmacological, psychological, and lifestyle based interventions which guide by the biopsychosocial model. Pharmacological interventions are focus on moderate to severe cases, use of antidepressants such as selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs) commonly prescribed for both depression and anxiety disorder, PTSD patients. In some cases, anxiolytics (e.g., benzodiazepines) can use for the short term management of acute anxiety symptoms. Psychotherapeutic interventions play a significant role, particularly in Cognitive Behavioral Therapy (CBT), which is effective therapy for all the three conditions by targeting negative thought patterns, emotional regulation, and behavior modification. On the other hand, other effective therapies include Mindfulness-Based Stress Reduction (MBSR), Dialectical Behavior Therapy (DBT), and Interpersonal Therapy (IPT), psychoeducation also use. Stress management techniques like relaxation techniques, guided imagery, progressive muscle relaxation, deep breathing exercises, and time management skills can reduce physiological and psychological symptoms of stress and anxiety. Lifestyle modification such as regular exercise, balanced nutrition, adequate sleep, and reduction of alcohol and caffeine intake can contribute in the treatment and overall well-being of individual. Moreover,social support systems from family, peers, or support groups, are essential. In more complex cases psychiatric consultation, psychosocial rehabilitation, and community-based mental health services, are needed. Early intervention, continuous monitoring, and individualized treatment plans, followup are needed to improving and preventing recurrence ,including the risk of suicidal ideation or behavior.

Globally, a significant body of research has been studied to identify and understand the causal factors of suicidal ideation and behavior, using biological, psychological and sociocultural factors. Studies shows that mental health disorders,such as major

depressive disorder, anxiety disorders, bipolar disorder, and substance use disorders are more vulnerable to cause suicidal ideation and attempts. Neurobiological research has uncovered associations between serotonin dysfunction, genetic polymorphisms (e.g.,5-HTTLPR), HPA axis dysregulation and altered brain structures such as the prefrontal cortex and amygdala, which influence emotional regulation and impulse control, which contribute to suicidal risk. Psychological studies reveals that the role of hopelessness, impulsivity, perfectionism,neuroticism, emotional dysregulation, and maladaptive coping mechanisms as proximal causal factors. Advances in neurobiological research, including brain imaging and genetic,autopsy studies, have identified the roles of neurotransmitter dysfunctions (e.g., dopamine, serotonin), HPA axis dysregulation and structural brain changes (e.g., in the amygdala and prefrontal cortex) which mediate the effects of stress and mood disorders on suicidal behavior. Psychological models, such as Beck's cognitive theory, Joiner's Interpersonal-Psychological Theory of Suicide and the Diathesis Stress Model, have explain the conceptual frameworks of understanding how negative thinking patterns, social isolation, and stress-related vulnerabilities increase suicidal risk.

Large-scale epidemiological studies, including the WHO World Mental Health Surveys, NIMH research, and European Alliance Against Depression (EAAD) initiatives, have linked to the socioeconomic stressors, unemployment,financial problems,conflicts in family, relationship breakdowns, chronic illness, and trauma exposure are the factors that trigger suicidal behavior, also when combined with preexisting psychological vulnerabilities. Cross-cultural research has explain that how stigma, cultural norms, access to means, gender roles, and lack of social support systems influence suicidal behavior differently across populations. More recently, longitudinal cohort studies and meta analysis explain the importance of early life experiences such as childhood abuse, neglect, parental mental illness as long term causal risk factors. Research emphasized that suicidal behavior is a multidimensional phenomenon, where biopsychosocial and cultural factors interact dynamically rather than act in isolation, and that comprehensive prevention requires addressing these diverse causal domains. Epidemiological studies, such as the World Mental Health Survey by the World Health Organization (WHO), revealed that depression and anxiety disorders are among the most common mental illnesses worldwide and both are strongly associated with increased risk of suicidal ideation and attempts.

Numerous longitudinal studies have shown that people has comorbidity depression and anxiety have a substantially higher risk of suicidal behavior.

Recent studies focus to sociocultural factors and regional differences in suicide risk, with research explain the impact of stigma, gender roles, socioeconomic status, and cultural beliefs on mental health and help seeking behavior. Moreover, the global COVID-19 pandemic has further emphasized the research efforts to investigate how increased stressors, social isolation, and economic instability have contributed to developing mental health problems and suicidal thoughts, behaviour across people.

Global public health initiatives, such as WHO's Mental Health Action Plan 2013–2030, and research funded by institutions like the National Institute of Mental Health (NIMH), have aim at improving early identification, diagnosis,intervention and treatment strategies and also implement prevention programs.

# Chapter II

# REVIEW OF LITERATURE

## REVIEW OF LITERATURE.

A literature review is a comprehensive review and analysis of published literature that relates to a particular research topic or question being studied. Various forms of literature are reviewed that can include journal articles, books, magazine and blog articles, published abstracts, conference proceedings, and dissertations. Literature review in research is one of the pillars on which the research idea stands since it provides context, relevance, and background to the research problem that the researcher are exploring.

A literature review, as defined by A.K. Singh in Tests, Measurements, and Research Methods in Behavioral Sciences, is a comprehensive and systematic examination of existing research, theories, and findings relevant to a specific topic. It involves identifying, analyzing, and synthesizing previous studies to understand the current state of knowledge, highlight gaps, and establish the foundation for new research. Singh emphasizes that a literature review is not just a summary but a critical evaluation that helps contextualize research questions, refine methodologies, and justify the need for further study.

**PURPOSE OF THE REVIEW:**

A collective body of works done by earlier scientists is technically called the literature. Any scientific investigation starts with a review of the literature. In fact, working with the literature is an essential part of the research process which generates the idea, helps in developing significant questions and is regarded as instrumental in the process of research design. The main objectives of a review of the literature are enumerated below.

1. **Identifying variables relevant for research** : When the researcher makes a careful review of the literature, he becomes aware of the important and unimportant variables in the concerned area of research. A careful review also helps the researcher in selecting the variables lying within the scope of his interest, in defining and operationalizing variables and in identifying variables which are conceptually and practically important. Thus a review of the literature, on the whole, preterite the researcher to formulate a researchable problem in literature,and practically important variables are selected.

2. **Avoidance of repetition**: A review of the literature helps the researcher in avoiding any duplication of work done earlier. A careful review always aims at interpreting prior studies and indicating their usefulness for the study to be undertaken. Thus prior studies serve as the foundation for present studies, In some cases, the duplication or replication of prior studies becomes essential. This is especially true when the researcher wants to test the validity of the earlier studies. In such a situation, too, a careful review helps the researcher in getting acquainted with the number and nature of the studies related to the study whose validity is being assessed at present.

3. **Synthesis of prior works:** A careful review of the literature enables the researcher to collect and synthesize prior studies related to the present study. This, in turn, helps him in building a better perspective for future research. A synthesized collection of prior studies also helps a researcher to identify the significant overlaps and gaps among the prior works.

4. **Determining meaning and relationship among variables:** A careful review of the literature enables the researcher in discovering important variables relevant to the area of the present research. When significant variables are discovered, the relationship among them can be identified. Subsequently, the identified relationship is incorporated into different hypotheses.

Thus, for conducting a scientific study, the relationship between the different variables must be explored by reviewing the literature so that a good context may be built up for subsequent investigations.

In addition to these specific purposes, there are some general purposes of the literature review:

(i) To argue for the relevance and the significance of the research question (ii) To provide the context for one's own methodological approach (iii) To establish one's own credibility as a knowledgeable and capable researcher (iv) To argue for the relevance and appropriateness of one's own approach

## SOURCES OF THE REVIEW

There are different sources of the review of literature. Some of them are enumerated below.

### Journals And Books

Different research journals and books relevant to the areas of interest are the primary sources of the literature review. Most major libraries have a periodical section where different types of research journals are made available easily. A research journal

generally contains the publication of original research reports with their detailed methodology and results. Such journals are referred and therefore are different from non referred journals. A referred journal is one which reports only those articles which are carefully reviewed by the experts before publication. Often, the reviewer rejects several manuscripts and selects a few for publication. Similarly, books are also direct sources of the literature review and they include textbooks, handbooks, yearbooks, dictionaries, etc. Of these two, journals are regarded as more useful because they provide the researcher with the latest and up-to-date information relevant to the area of interest.

**Reviews**

Reviews are short articles that give brief information regarding the work done in a particular area over a period of time. Reviews are commonly published in journals, yearbooks, handbooks and encyclopedias. Reviewers select research articles of their interest, organize them content wise, criticism their findings and offer their own suggestions and conclusions. Review articles are a good source for those investigators who wish to have all the relevant researches at one place without taking pains to look for them. Since the reviewers organize all the possible research papers of the relevant area in their review articles, review articles also provide the advantage of prior reviews.

**Abstracts**

Abstracts provide a summary of the research reports done in different fields. Psychological Abstracts (Washington: American Psychological Association) first published in 1927, and Sociological Abstract (New York: Sociological Abstracts, INC) are the two common examples of abstracts. Other sources of abstracts are Educational Resources Information Centre (ERIC), Dissertation Abstracts International, children research abstract and the Indian Education Abstracts (published by NCERT, New Delhi). These abstracts are useful sources of up-to-date information for researchers. In an abstract, besides a summary, researchers get all the relevant information such as the title of the research report, name of the author and the journal pagination information, etc., regarding the research article. The only limitation of abstracts is that they fail to satisfy those researchers who desire detailed information regarding the methodology and results of the research articles.

**Indexes**

Indexes show the titles of the research report without any abstract. The titles are categorized and arranged alphabetically in each category so that the researcher can locate any article of interest easily. The Education Index (New York: H W Wilson Co.) is a good example of an index. As indexes do not provide detailed information, they keep many a researcher dissatisfied. They can be best regarded as a supplementary source which, if combined with other sources, can yield valuable information to the researchers.

**Internet**

Today the internet is a very easy and quick source of literature review. Internet sites are very useful for providing easy access to original writings by important researchers. They also provide an updated information on the topic that ordinarily is not available in the library. Internet sites also provide useful bibliographies related to a particular researcher. Search on the internet also reveals

some relevant professional societies and academic associations which can provide a lot of support to the studies in the concerned area. Such organizations also sometimes publish important papers or periodicals which can be of immense help to the researchers. Some publishers put the brief content and extracts from recently published books on the Internet and these can be of valuable help to the researchers. Sometimes, the internet sites include articles extracted from encyclopedias which can also be very useful and informative as background reading. However, they are not normally suitable for citing in a thesis.

**Doctoral Dissertations**

Doctoral dissertations have also been a very good source of the review of the literature. In libraries of universities, doctoral dissertations are available. The researcher can choose the dissertations of their interest and find useful and relevant information there. There are no set forms of writing the research report in a doctoral dissertation but most dissertations contain chapters like an introduction, review of the literature, purpose of the study, method of the study, results, discussion, summary and conclusion. Some researchers prefer not to add a separate chapter on the review of the literature and hence, it is incorporated into the introduction itself.

Thus the doctoral dissertations present the advantage of prior review. Ordinarily, it is not possible for the researcher to move through all the important libraries in the country to consult all existing doctoral dissertations. Hence, he can have access to

those dissertations that interest him through Dissertation Abstracts International, which publishes the abstracts of the doctoral dissertations submitted to different universities. In India, the Survey of Research in Education (edited by M B Buch) does much the same function. The second Survey of Research in Education covering the period between 1972-78 has been released. Recently, the listing of dissertation abstracts has been computerized through DATRIX in terms of the key words (usually words appearing in the title of the dissertation).

**Supervisors/Research Professors**

Supervisors often know the literature well and are able to guide researches in the right direction.They are the recognized authority on the topic or research problems. Therefore, they should be consulted and their suggestions and advice should be carefully analyzed. It may also be that other research professors have recently sourced and reviewed the literature or an area very close to the literature that the researcher is seeking. So they also constitute one important source.

Whatever may be the sources of reviews, the process of reviewing literature itself is not above criticisms. Inevitably the interpretation of findings, insights derived, the manner in which conclusions are drawn are all solely dependent upon the judgments of the reviewer. In other words, such reviews fall prey to what is called subjective judgement.

There is an increase in suicidal behaviour in the western world providing a major challenge to health care providers. There is an increase in the number of suicides among elderly people in Europe. The problem of suicides among elderly people is in itself a social problem, not solely a medical one. The general practitioner may be the only source of social contact for the elderly. Elderly individuals often present their problems to doctors as somatic complaints; these complaints must not be taken at face value but understood as expressions of psychosocial and social distress. The rise in suicide rates among young people is also alarming. The warning signs of escalating distress in adolescents are known and a treatment programme coordinating medical initiatives, such that recidivism of suicidal behaviour in adolescents is reduced, is necessary. The general practitioner is urged to sense when the problem presented by the individual stems from a source which is predominantly social, and to suggest an appropriate solution which may entail a family intervention. The general practitioner is in the front line of treatment and he or she may be better advised to treat both the

social situation and the individual person in cases of attempted suicide. Medical initiatives must incorporate aspects of social medicine whereby community solutions are found for the management of individual distress. Social disruption, isolation, conflict and neglect are the doors to the house of despair. While medicine must respond to those who enter that house, it is the social level at which we must be the architects of change. People will die (Beautrais, A. L., 2000).

Suicide rates in young people have increased during the past three decades, particularly among young males, and there is increasing public and policy concern about the issue of youth suicide in Australia and New Zealand. This paper summarize current knowledge about risk factors for suicide and suicide attempts in young people. Evidence about risk factors for suicidal behaviour in young people was gathered by review of relevant English language articles and other papers, published since the mid-1980s.The international literature yields a generally consistent account of the risk factors and life processes that lead to youth suicide and suicide attempts. Risk factor domains which may contribute to suicidal behaviour include: social and educational disadvantage; childhood and family adversity; psychopathology; individual and personal vulnerabilities; exposure to stressful life events and circumstances; and social, cultural and contextual factors. Frequently, suicidal behaviour in young people appear to be a consequence of adverse life sequences in which multiple risk factors from these domains combine to increase risk of suicidal behaviour. Current research evidence suggests that the strongest risk factors for youth suicide are mental disorders (in particular, affective disorders, substance use disorders and antisocial behaviour) and a history of psychopathology, indicating that priorities for intervening to reduce youth suicidal behaviors lie with interventions focused upon the improved recognition, treatment and management of young people with mental disorders (Pelkonen, M., & Marttunen, M,2003).

Suicides are a hidden and unrecognized epidemic in the Indian region, affecting predominantly younger age groups. Information on causative risk factors and mechanisms is not available in the country, which is crucial for designing intervention programme. To identify and quantify risk factors for completed suicides in the city of Bangalore.Methods. A case–control study was conducted with the families of 269

completed suicides and 269 living controls within the broader population of the city using psychological autopsy methods.Results. The study has shown that several factors in the areas of family, marriage, education, occupation, general health, mental health and absence of protective factors contribute significantly for suicides. The cumulative and repetitive interaction of several factors in a complex manner results in suicides. The significant factors were presence of previous suicidal attempt in self (odds ratio (OR) = 42.62), interpersonal conflicts and marital disharmony with spouse (OR = 27.98), alcoholism in self (OR = 23.38), presence of a mental illness (OR = 11.07), sudden economic bankruptcy (OR = 7.1), domestic violence (OR = 6.82) and unemployment (OR = 6.15). Individuals completing suicides did not have a positive outlook towards life, problem-solving approaches and coping skills.Conclusion. The observed findings are at variance with suicidal causation in the West in some areas operating in a different sociocultural and economic environment. The intervention strategies should include prioritized macro and micro level efforts aimed at individual, family and society (Gururaj, G., Isaac, M. K., Subbakrishna, D. K., & Ranjani, R. 2004).

To estimate the life prevalence rates of suicidal ideation, suicidal plans and suicide attempts and verify factors associated to suicidal ideation. METHODS: 515 individuals > 14 years old were selected at random (cluster and stratified sample) and assessed by means of the WHO SUPRE-MISS interview, SRQ-20 and AUDIT. Life prevalence rates were estimated. Uni and multivariate analyses were performed. Odds ratios, together with confidence intervals, were adjusted by gender and age. RESULTS: Life prevalence rates were 17.1% (95% CI: 12.9 - 21.2) for suicidal ideation, 4.8% (95% CI: 2.8 - 6.8) for plans and 2.8% (95% CI: 0.09 - 4.6) for suicide attempts. Only one-third of those who attempted suicide were later treated at a health facility. The 12-month prevalence rates were, respectively, 5.3% (95% CI: 3.5 - 7.2), 1.9% (95% CI: 1.0 - 2.8) and 0.4% (95% CI: -0.3 - 1.1). Suicidal ideation was more frequently reported by women (OR = 1.7), young adults (20-29 years old: OR = 2.9; 30-39 years old: OR = 3.6, compared to the 14-19 year old group), those living alone (OR = 4.2) and those presenting mental disorders (OR between 2.8 and 3.8). CONCLUSION: The prevalence of suicidal behavior was similar to that found in most studies carried out in other countries. Suicidal ideation was consistently associated with factors related to mental disorders or psychological distress. This

should be taken into account when developing strategies to prevent suicidal behavior(Botega, N. J., Barros, M. B. D. A., Oliveira, H. B. D., Dalgalarrondo, P., & Marín-León, L. ,2005).

Suicidal ideation and suicide attempt are generally considered as non-fatal suicidal behaviors (NFSB) by most researchers. Across different cultures, the prevalence of NFSB has been found to be alarmingly high among adolescents. As there is no published study estimating prevalence rates in India, we conducted a study on adolescents in Delhi to find prevalence of NFSB and other related behaviors and to identify risk factors for NFSB.Methods: We collected data from 1205 adolescents in the age group from 12 to 19 years from 2 schools through semi-structured questionnaire on demographic variables, NFSB, death wish, deliberate self harm (DSH), Adjustment Inventory for School Students (AISS) by Sinha et al. & BDI.Results: Prevalence of suicidal ideation (lifetime), suicidal ideation (last year), suicide attempt (lifetime), suicide attempt (last year) were 21.7%, 11.7%, 8% and 3.5%, respectively. All the significant variables were entered into a logistic regression analysis model, and the adjusted odds ratios, with 95% confidence intervals, were obtained for them. Hindu religion, female sex, older adolescent, physical abuse by parents, feeling neglected by parents, history of running away from school, history of suicide by a friend, death wish and DSH were found to be significant risk factors for NFSB.Conclusions: There is high prevalence of suicidal ideation, suicide attempt, death wish and deliberate self-harm in adolescent population of two schools in Delhi. Clinical implications of these findings are discussed (Sidhartha, T., & Jena, S. ,2006).

Recognizing the complementary effects of social contexts and psychiatric disorders, this study clarifies the role of gender in suicidal behavior in urban Mumbai by considering psychiatric diagnoses and patient-identified sociocultural features. The cultural epidemiological approach suggests the critical impact of situational sociocultural factors that complement the customary psychopathological accounts for those who harm or kill themselves. The cultural epidemiology of deliberate self-harm (DSH), it is argued, is critical to planning for suicide prevention, community mental health and psychiatric practice. This study, based on a cultural epidemiological framework, compares male and female admissions for DSH, evaluating conditions with SCID-I and EMIC interviews. We assessed features and narratives of suicidal

behavior, patient-identified underlying problems, their perceived causes and triggers. The study included 92 women and 104 men. A diagnosis of depressive disorder was made for 48.9 percent of women and 39.4 percent of men. Many patients (50.0 percent of women and 41.3 percent of men) did not fulfill the criteria for any diagnosis, or did so only for an adjustment disorder or a V-code. Men typically explained DSH with reference to work problems, financial problems and problem drinking. Women typically discussed domestic problems, in-law relations and victimization. Problem drinking affected women living with men who drank. Social and situational factors appear to play a relatively greater role than psychiatric illness in self-harm and suicide in Mumbai, as in other Asian studies, compared with Europe and North America (Parkar, S. R., Dawani, V., & Weiss, M. G. ,2008).

Background Suicide among young people has emerged as a major public health issue in many low- and middle-income (LAMI) countries. Suicidal behaviour including ideation and attempt are the most important predictors of completed suicide and offer critical points for intervention. The aim of this study is to estimate the prevalence and risk factors for suicidal behaviour in young people in India.Method and findings Cross-sectional study of 3662 youth (16–24 years) from rural and urban communities in Goa, India. Suicidal behaviour during the recent 3 months and associated factors were assessed using a structured interview. Overall 144; 3.9% [95% confidence interval (CI) 3.3–4.6] youth reported any suicidal behaviour in the previous 3 months. Suicidal behaviour was found to be associated with female gender Odds ratio (OR) 6.5 (95% CI 3.9–10.8), not attending school or college OR 1.6 (95% CI, 1.01–2.6), independent decision making OR 2.5 (95% CI 1.5–4.3), premarital sex OR 3.2 (95% CI 1.6–6.3), physical abuse at home OR 3.3 (95% CI 1.8–6.1), life time experience of sexual abuse OR 3.3 (95% CI 1.8-6.0) and probable common mental disorders (CMD) OR 9.5 (95% CI 6.3–14.5). Gender segregated analysis found independent decision making ($P = 0.68$ for interaction), rural residence ($P = 0.01$ for interaction) and premarital sex ($P = 0.41$ for interaction) retained association with suicidal behaviour only among females ($P < 0.05$). The population attributable fraction estimates were largest for CMD (42.8% for females; 35.9% for males); physical abuse in one's home (12.5% for females; 12.4% for males); sexual abuse (12.1% in females; 22.3% in males); and making independent decisions (22.9% for females). Analyses of the risk factors for the relatively less common outcome of

suicide attempts found a similar set of factors as for suicidal behaviour; in addition, alcohol use was also an independent risk factor.Violence and psychological distress are independently associated with suicidal behaviour; factors associated with gender disadvantage—in particular for rural women, may increase their vulnerabilities. Prevention programs for youth suicide in India need to address both the structural determinants of gender disadvantage, and the individual experiences of violence and poor mental health.Investigating suicidal trend and its economic determinants: evidence from India (Pillai, A., Andrews, T., & Patel, V. 2009).

This paper examines the trend and economic determinants of the suicidal deaths in India. Time-series data over the period 1967-2006 is used from various sources. The paper analyzes the suicidal trend and exploratory relationships between suicide rate and some of the demographic and other economic variates. Further, we use ARDL model to find out the association between suicide and some economic variables. We find that inflation, per capita real GDP and industrial growth encourages the incidences of suicides whereas increased per capita household income helps in reducing suicidal deaths in India (Pandey, M. K., & Kaur, C. 2009).

The relative contributions of psychosocial stress and psychiatric morbidity to suicide are a subject of debate.To determine major risk factors for suicide in rural south India.We used a matched case–control design and psychological autopsy to assess 100 consecutive suicides and 100 living controls matched for age, gender and neighbourhood.Results:Thirty-seven (37%) of those who died by suicide had a DSM–III–R psychiatric diagnosis. Alcohol dependence (16%) and adjustment disorders (15%) were the most common categories. The prevalence rates for schizophrenia, major depressive episode and dysthymia were 2% each. Ongoing stress and chronic pain heightened the risk of suicide. Living alone and a break in a steady relationship within the past year were also significantly associated with suicide. Psychosocial stress and social isolation, rather than psychiatric morbidity, are risk factors for suicide in rural south India.Prevalence and social determinants of suicidal behaviours among college youth in India (Manoranjitham, S. D., Rajkumar, A. P., Thangadurai, P., Prasad, J., Jayakaran, R., & Jacob, K. S. 2010).

Little is known about the prevalence of and factors associated with suicide ideation and suicide attempts among college youth in India.The aims were to estimate the prevalence of suicidal behaviour among Indian college students and identify potential risk factors for suicide ideation and attempts.Method:The study surveyed 1,817 undergraduate college students aged 18–24 years in Ahmedabad, Gujarat, with a questionnaire that assessed suicidal behaviours as well as stressful situations and life events. Logistic regression analysis was used to assess risk factors.Results:The prevalence of lifetime suicide ideation and lifetime suicide attempts was 11.7% and 4.0%, respectively. Suicide ideation was predicted by female gender, odds ratio (OR) = 1.41, 95% CI 1.01, 1.97, economic stress, OR = 1.17, 95% CI 1.11, 1.24, stress due to life events involving religious violence in the community, OR = 1.43, 95% CI 1.15, 1.78, and life events involving caste conflicts or caste discrimination, OR = 1.28, 95% CI 1.13, 1.46. Female gender and caste-related life events were not significantly associated with suicide attempts but economic stress and stressful experience of religious conflict continued to be significantly associated with lifetime suicide attempt, OR = 1.19, 95% CI 1.08, 1.31, and OR = 1.58, 95% CI 1.14, 2.17, respectively.Conclusions:In this sample, college students from low socioeconomic classes who faced economic difficulties, and students who experienced distress as a result of caste discrimination or caste conflict, and communal unrest, were at a higher risk for suicidal behaviour (Nath, Y., Paris, J., Thombs, B., & Kirmayer, L. 2012).

Suicide has been around for as long as human society, ranking among the top 13 causes of death in all ages worldwide and continues to challenge our collective wisdom. The present study is a retrospective study evaluating suicide cases in Lucknow, capital of Uttar Pradesh and one of the largest cities in India, between Jan 2008 and Oct 2012. There were 5204 cases with 2946 male (56.61%) and 2258 female (43.38%) victims, between ages 20 and 60 years; suicide rates ranged from 21.55 to 24.23 per 100,000 population. The method of suicide was different between male and female victims, as male victims tried to use more violent methods than females. The present study showed that suicide rates have increased since 1994, indicating a grave problem that needs to be solved (Kumar, S., Verma, A. K., Bhattacharya, S., & Rathore, S. 2013).

Intent in attempted suicide is considered an indicator of subsequent suicide. Few studies in developing countries have examined correlates of suicidal intent among young adults.This study aimed to assess the intent score among a sample of young suicide attempters from South India and to identify the factors associated with suicide intent among them. The clinical charts of 64 consecutive subjects aged 15–24 years attending emergency services for attempted suicide were reviewed. All participants completed a semistructured proforma, the Presumptive Stressful Life Events Scale, the Beck Hopelessness Scale, the Pierce Suicide Intent Scale, and the Global Assessment of Functioning Scale. Psychiatric diagnoses were made according to the ICD-10 clinical descriptions and diagnostic guidelines.The intent scores were in the moderate-to-high range for most subjects. Suicide intent score significantly varied depending on the presence or absence of psychiatric morbidity. In bivariate analysis, psychiatric morbidity and hopelessness correlated positively with suicide intent, and in linear regression, hopelessness emerged as a predictor of suicide intent.A high intent of suicide in young is associated with psychiatric morbidity and presence of hopelessness. Hopelessness may be a key predictor of suicidal intent. Assessment of suicidal intent and hopelessness among young attempters is important and may help identify high-risk individuals who need intensive interventions (Menon, V., Kattimani, S., Shrivastava, M. K., & Thazath, H. K. ,2013).

The study examines the prevalence of suicidal ideation and suicide attempt, and associated factors among school-going urban adolescents in Peru. A cross-sectional survey was conducted in a sample of 916 secondary school adolescents in 2014. A structured questionnaire adapted from Global School-based Student Health Survey was used to obtain information. Data were analyzed using logistic regression models at 5% level of significance. Overall, 26.3% reported having suicidal ideation, and 17.5% reported having attempted suicide during the past 12 months. Multivariate logistic regression analysis showed that female sex, being in a fight, being insulted, being attacked, perceived unhappiness, smoking and sexual intercourse initiation were significantly associated with increased risk of suicidal ideation, while female sex, being in a fight, being insulted, being attacked, perceived unhappiness, alcohol and illicit drug use were related to suicide attempt. The prevalence of suicidal ideation and suicide attempts observed in the survey area is relatively high. Female adolescents are particularly vulnerable to report suicidal ideation and suicide attempt. Interventions

that address the issue of violence against adolescents, fighting with peers, health risk behaviors particularly initiation of smoking, alcohol and illicit drug use and encourage supportive role of parents may reduce the risk of suicidal behaviors (Sharma, B., Nam, E. W., Kim, H. Y., & Kim, J. K. ,2015).

Suicide is a leading cause of death and a complex clinical outcome. Here, we summarize the current state of research pertaining to suicidal thoughts and behaviors in youth. We review their definitions/measurement and phenomenology, epidemiology, potential etiological mechanisms, and psychological treatment and prevention efforts.Results:We identify key patterns and gaps in knowledge that should guide future work. Regarding epidemiology, the prevalence of suicidal thoughts and behaviors among youth varies across countries and sociodemographic populations. Despite this, studies are rarely conducted cross-nationally and do not uniformly account for high-risk populations. Regarding etiology, the majority of risk factors have been identified within the realm of environmental and psychological factors (notably negative affect-related processes), and most frequently using self-report measures. Little research has spanned across additional units of analyses including behavior, physiology, molecules, cells, and genes. Finally, there has been growing evidence in support of select psychotherapeutic treatment and prevention strategies, and preliminary evidence for technology-based interventions.Conclusions:There is much work to be done to better understand suicidal thoughts and behaviors among youth. We strongly encourage future research to: (1) continue improving the conceptualization and operationalization of suicidal thoughts and behaviors; (2) improve etiological understanding by focusing on individual (preferably malleable) mechanisms; (3) improve etiological understanding also by integrating findings across multiple units of analyses and developing short-term prediction models; (4) demonstrate greater developmental sensitivity overall; and (5) account for diverse high-risk populations via sampling and reporting of sample characteristics. These serve as initial steps to improve the scientific approach, knowledge base, and ultimately prevention of suicidal thoughts and behaviors among youth (Cha, C. B., Franz, P. J., M. Guzmán, E., Glenn, C. R., Kleiman, E. M., & Nock, M. K,2018).

Suicidal behavior is a leading cause of injury and death worldwide. It is a public health issue that is estimated to contribute more than 2.4% to the global burden of

disease by the year 2020. University and college students are among groups affected more than the general population. However, there is a scarcity of studies on the magnitude and associated factors of suicidal behavior among University students in Ethiopia, particularly in Mettu University. Therefore, we assessed the prevalence of suicidal behavior and associated factors among Mettu University students.Methods:Institution-based multistage stratified cross-sectional study design was conducted among 523 regular main campus students of Mettu University. The Suicidal Behaviors Questionnaire Revised (SBQ-R) was used to screen the presence of suicidal behavior symptoms. Data analysis was done using SPSS version 20.Results:Lifetime prevalence of suicidal ideation, plan, and attempt was 58.3%, 37.3%, and 4.4%, respectively, with one-year prevalence of suicidal ideation at 34%. The multivariate logistic regression analysis revealed that the odds of suicidal ideation were higher among female gender, students who had poor social support, family history of suicide attempt, lifetime alcohol use, rural residence, and less frequently engaging in religious practice; these factors were significantly associated with suicidality.Conclusion:Nearly one-fourth of respondents report suicidal behavior. Prevalence of suicide was found to be higher. Prevention and coping actions regarding identified factors to reduce burden of suicide are needed (Abdu, Z., Hajure, M., & Desalegn, D,2020).

The Union Territory of Puducherry has a high rate of suicide in India. This study aims to find the prevalence of suicidal ideation, plan and suicide attempts and the risk factors of suicidal behaviours.This community-based cross-sectional study was conducted among adults aged 18 years and above in rural and urban areas of Puducherry, India. Columbia Suicide Severity Rating Scale questionnaire was used. Prevalence ratio was estimated to assess the factors associated.The 12-month and lifetime prevalence of suicidal ideation was reported to be 12.5% (95% CI: 10.4–15.0%) and 20% (95% CI: 17.4–22.9%), respectively. About 0.7% (95% CI: 0.3–1.5%) and 2.1% (95% CI: 1.2–3.3%) of the participants had suicide plan in past 12 months and ever in their lifetime, respectively. Around 1% (95% CI: 0.5–2.0%) and 5.7% (95% CI: 4.3–7.6%) of the participants had attempted suicide in past 12 months and ever in their lifetime, respectively. Family issues, physical abuse, unemployment and place of residence were significantly associated with suicidal ideation in multivariable analysis.Prevalence of suicidal ideation and suicide attempt

were very high in the study area. Unemployment, physical abuse and family issues were significantly associated with suicidal behaviour (Singh, A., Saya, G. K., Menon, V., Olickal, J. J., Ulaganeethi, R., Sunny, R., ... & Chinnakali, P,2021).

Concerns about whether fictional media can have a contagion effect on youth viewers have been debated for several decades. In the 1980s these led to several lawsuits featuring heavy metal acts as defendants. More recently, concerns have been renewed following the popular television show 13 Reasons Why which depicts an adolescent girl's suicide. The current study examines these concerns in a survey study of 174 youth and their caregivers. Results indicated that, contrary to concerns, viewing suicide themed fictional shows was associated with reduced depressive symptomology and was not associated with suicidal ideation specifically. Depression and suicidal ideation were most associated with experiencing with others' suicides in real life, family environment, bullying and neurotic personality traits. The show 13 Reasons Why specifically was associated with either lower depression or suicidal ideation or null effects, depending on specific outcome. Although correlational, this evidence suggests that suicide prevention efforts should focus less on fictional media and more on prevention of bullying (CJ Ferguson, Taylor & Francis, 2021).

India reports the highest number of suicide deaths in the world. At this time when the Indian Government is formulating a national suicide prevention strategy, we have reviewed the current status of suicides in India, focusing on epidemiology, risk factors, and existing suicide prevention strategies to identify key challenges and priorities for suicide prevention. The suicide rate among Indian girls and women continues to be twice the global rate. Suicide accounts for most deaths in the 15–39 years age group compared with other causes of death. Hanging is the most common method of suicide, followed by pesticides poisoning, medicine overdose, and self-immolation. In addition to depression and alcohol use disorders as risk factors, several social and cultural factors appear to increase risk of suicide. The absence of a national suicide prevention strategy, inappropriate media reporting, legal conflicts in the interpretation of suicide being punishable, and inadequate multisectoral engagement are major barriers to effective suicide prevention. A scaffolding approach is useful to reduce suicide rates, as interventions provided at the right time, intensity, and duration can help navigate situations in which a person might be susceptible to and at risk of

suicide. In addition to outlining research and data priorities, we provide recommendations that emphasize multilevel action priorities for suicide prevention across various sectors. We call for urgent action in India by integrating suicide prevention measures at every level of public health, with special focus on the finalization and implementation of the national suicide prevention strategy (Garg, S., Chauhan, A., Singh, S., & Bansal, K,2022).

Suicidal behavior can be broadly subdivided into suicide-related behavior and suicide-related communication. Amidst the broad array of confusing terms with varying meanings, the terms as used in this guideline have been clarified for the sake of uniformity of communication and approach between clinicians (Sarkhel, S., Vijayakumar, V., & Vijayakumar, L.,2023).

It is true that suicide is an increasing serious global public health issue currently, 9 deaths per One Lacs and 1 death every 40 seconds (WHO), and it has been increasing year by year globally as well as in India, 12 deaths per One Lacs (NCRB, 2022). And the age group between 18 to 45 is most vulnerable group where the suicide rate is nearly 33% of the total suicides. Suicide is an end outcome of complex interactions between environmental, sociological, biological, psychological, genetical factors. India has also been facing a high rate of suicide from last few years mainly in young adults age group. However, research in this area is limited and need more investigation and understanding about the more complex underlying factors contributing to suicide, such as social, demographic, cultural, psychological, psychiatric, environmental and economic factors to develop effective prevention strategies, and Covid-19 pandemic also causing increasing rates of suicide in India. Suicide is not an accidental phenomenon, it has precedents of suicidal ideation, suicidal thoughts, suicidal attempts and leading to completion. Therefore, suicide ideation is a leading precursor for suicide under influence of other psychosocial, psychological, socioeconomic, biological, psychiatric, and other environmental correlates. Present review paper is aimed to identify the various variables associated with suicidal ideation by review of existing literature available on suicide attempts, suicide and suicide ideation in Indian context (Sharma, M. L., & Kumar, V,2024).

Suicide is the significant public health concern globally,Research has conducted on risk factors such as depression, anxiety, stress with complex interplay of biological, psychological, social factors. Furthermore, gaps persist in research in understand the intricate interplay of these variables,the effectiveness of prevention strategies, programme and the evolving understanding the demographic trends which influencing the suicidal ideation and behaviour. Research findings in Psychological Factors of **Depression** is widely recognized as the most important predictor of suicidal ideation and attempts. Studies shows that individuals with major depressive disorder (MDD) have a significantly high suicidal risk. **Anxiety** is also contribute to suicide risk, but the exact mechanisms remain less clear. Some previous studies suggest that comorbid with anxiety and depression lead to increased suicidal ideation. **Stress and Trauma** play a important role in enhancing suicidal risk, particularly among vulnerable individuals such as adolescents, youth group, military personnel, and individuals with a history of abuse or bullying, harsh life experiences. Social and environmental, Demographic Variables like **Socioeconomic factors**, including unemployment, financial problems, and lack of social support,interpersonal conflicts have been linked to increased suicide risk. **Gender and age** differences show that males have higher suicide rates, whereas females have higher rates of suicide attempts. Implementation Prevention Strategies and Interventions is crucial to reducing the risk factors. **Psychological therapies** such as Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT) have shown effectiveness in reducing suicidal ideation. **Community based interventions**, including crisis interventions and awareness programs, have had mixed success in reducing suicide rates. **Pharmacological approaches** like antidepressants and mood stabilizers are widely used but require close monitoring due to the risk of increased suicidal thoughts in certain individuals.

Gaps in Research and Areas for Further Study required are Interaction Between Depression, Stress, and Anxiety While individual effects of depression, anxiety, and stress on suicide risk are well studied, few studies explore how these factors interact dynamically. Future research should examine, Whether the combined effect of these variables increases suicide risk beyond their individual contributions. The existence of threshold levels where stress and anxiety significantly enhance suicidal ideation. Longitudinal studies to assess how chronic stress and persistent anxiety influence

suicide risk over time. Investigations into whether different stressors (acute vs. chronic) affect suicidal behavior differently. Few studies comprehensively analyze factors that might worsen suicide risk, such as the role of social support, coping mechanisms, and resilience in reducing the effects of depression and stress. How demographic factors (age, gender, socioeconomic status) moderate the relationship between psychological distress and suicidal ideation. Research has predominantly focused on adolescents and elderly populations, but less attention has been given to the impact of workplace stress, burnout, and job insecurity on suicide risk. The influence of academic pressure, perfectionism, and performance related to stress on individuals mental health.

There is limited research linking biological factors to suicide risk. Future studies could explore that How variations in **cortisol levels (stress hormone)** interrelates with suicidal risk. The role of **neurotransmitter imbalances** in influencing the effects of depression and anxiety on suicide risk. While extensive research has been conducted on suicide risk factors and prevention, significant gaps remain. Future studies should focus on the **interplay of depression, anxiety, and stress**, **longitudinal impacts**, **moderating influences**, and **biological mechanisms**. Addressing these gaps can enhance targeted prevention efforts and improve mental health and over all well being of individual.

The existing body of research on suicide trends and prevention defines the multifaceted nature of suicidal ideation and behaviour which influenced by psychological, social, and environmental factors. Several studies focus on the role of mental health conditions, particularly depression, anxiety, and stress, as significant predictors of suicidal behavior. The literature also explores demographic variations, including age, gender, socioeconomic status, and cultural influences, in understanding suicide risks. Moreover, various prevention strategies, such as early psychological interventions, crisis helplines, and policy driven approaches, have been examined for their effectiveness.

Despite these advancements, research gaps persist where the further analysis is required there is One major limitation is the insufficient exploration of the interplay between depression, stress, and anxiety in suicidal ideation. While individual studies focus on each factor separately, few comprehensively analyze how these variables

interact and contribute to suicide risk. There is limited research on the intervention strategies that address depression, stress, and anxiety in youth populations by using validated psychometric scales. Additionally, there is limited longitudinal research that tracks individuals over time to determine causality. Another gap lies in the contextual influences of suicide, such as social media exposure, economic instability, and emerging global crises, which are under explored in the current literature. Furthermore, preventive measures have been studied, their long term effectiveness and adaptability to different populations remain unclear.

Addressing these gaps requires more strong interdisciplinary research that integrates psychological, social, and economic perspectives. Future studies should also employ diverse methodologies, including qualitative analyses to develop a more subtle understanding of suicide risk factors and interventions.

Based on the importance of the risk factors for suicidal ideation and behaviour in youth and the present study aimed to examine the interrelationship between stress, anxiety, depression and associated factors with the emergence of suicidal ideation/behavior in youth.

# Chapter III

# METHODOLOGY

## RESERCH METHODOLOGY

The present study focus on gender differences in depression, anxiety, stress, suicidal ideation, and suicidal behavior among youth, by using two well established psychological assessment tools: the Depression Anxiety Stress Scales-21 (DASS-21) and the Columbia Suicide Severity Rating Scale (C-SSRS). The purpose of the study is to compare and explore how these variables differ between male and female youth group, providing a comprehensive understanding of mental health challenges faced by different genders. Given the rising prevalence of mental health issues and suicidal behavior among youth, this study aims to identify patterns and relationships that may inform future prevention and intervention efforts.

**Methodology** refers specific procedures or techniques used to identify, select, process and analyse data or information about a topic. in other words it is a structured framework of conducting research in order to address various issues and solve problems.

**Research methodology** is the systematic approach used to conduct research, including the principles, techniques, and procedures for collecting, analyzing, and interpreting data. It ensures the reliability and validity of findings by providing a structured framework for inquiry.

According to A.K. Singh, "Research methodology refers to the systematic, theoretical analysis of the methods applied to a field of study. It involves the principles, procedures, and techniques used to identify, collect, process, and analyze information to understand a research problem or find solutions."

According to C.R. Kothari, "Research methodology is a way to systematically solve the research problem. It may be understood as a science of studying how research is done scientifically. In it, we study the various steps that are generally adopted by a researcher in studying his research problem along with the logic behind them."

In the present study an attempt has been made to compare between male and female on the basis of the five dimensions, these are depression, anxiety, stress, suicidal ideation, and suicidal behaviour.

The standardized tools are regarded as the basis for an evidence based assessment. It is a type of evaluation tool which have established statistical validate and reliable. Established and standardized tools evaluate responses in a way through which resulting dimensions can be operationally defined.

The dimensions of stress, depression and anxiety have been measured by Depression Anxiety Stress Scales- Short Form (DASS-21) (By Syd Lovibond and Peter Lovibond, 1995),is a self-report questionnaire, It consists of 21 items, with seven items for each domain, rated on a 4 point likert scale. Depression items assess feelings of hopelessness, self-deprecation, and low energy. Anxiety items evaluate physical arousal and subjective feelings of fear, while stress items capture irritability, restlessness, and difficulty in relaxation. This tool is psychometrically validated, making it reliable for evaluating emotional states across different populations. In addition to DASS-21, the study employs the Columbia- Suicide Severity Rating Scale (C-SSRS), a clinician administered and self-report tool developed by Posner et al in 2007, which assesses the severity and intensity of suicidal ideation and behavior. This scale records information on suicidal thoughts, attempts, and related behavior, helping to understands the participants risk levels.

Ethical considerations play a crucial role in this study. Participants are approached individually, and informed consent is obtained after a thorough explanation of the study purpose, confidentiality protocols, and their right to withdraw at any time. To maintain anonymity, no identifying information is collected, and all responses are stored securely.

The data collection process involves administering both the DASS-21 and the C-SSRS through paper and pencil forms. Instructions are provided in clear and simple language which is easy to understand the participants. The use of the DASS-21 and C-SSRS ensures the study captures both emotional distress and suicidal tendencies comprehensively. The combination of quantitative methods and a comparative gender analysis offers a detailed understanding of mental health disparities between male and female youth. The findings of this study are expected to contribute to the growing body of knowledge on youth mental health, offering evidence based insights to inform mental health professionals, educators in designing gender sensitive prevention and intervention programs. Furthermore, the study aims to highlight the importance of early identification and implement mental health support to reduce the risk of suicide and improve overall well-being among youth.

**OBJECTIVES:**

The present study was aimed -

- To find out if there is any significant difference between Male and Female youth with respect to depression.
- To find out if there is any significant difference between Male and Female youth with respect to anxiety.
- To find out if there is any significant difference between Male and Female youth with respect to stress.
- To find out if there is any significant difference between Male and Female youth with respect to suicidal ideation.
- To find out if there is any significant difference between Male and Female youth with respect to intensity of suicidal ideation.
- To find out if there is any significant difference between Male and Female youth with respect to suicidal behaviour.
- To find out if there is any significant difference between Male and Female youth with respect to Actual lethality of Suicide attempts.
- To find out if there is any significant difference between Male and Female youth with respect to Potential lethality of suicide attempts.
- To understand the relationship between depression, anxiety, stress among youth.
- To understand the relationship between suicidal ideation and behaviour among youth.

**HYPOTHESIS:**

On the basis of previous studies, following hypothesis were formulated-

- HI: There is a significant mean difference between Male and Female in respect to depression level.
- H2: There is a significant mean difference between Male and Female in respect to anxiety level.
- H3: There is a significant mean difference between Male and Female in respect to stress level.
- H4: There is a significant mean difference between Male and Female in respect to Suicidal Ideation.
- H5: There is a significant mean difference between Male and Female in respect to Intensity of Ideation.
- H6: There is a significant mean difference between Male and Female in respect to suicidal behaviour.
- H7: There is a significant mean difference between Male and Female in respect to Actual lethality of Suicide attempts.
- H8: There is a significant mean difference between Male and Female in respect to Potential lethality of suicide attempts.
- H9:There is a significant relationship between Depression,Anxiety,Stress among Male and female youth.
- H10: There is a significant relationship between suicidal behaviour and suicidal ideation among Male and female youth.

**For the present study these dimensions have defined operationally**

**OPERATIONAL DEFINATIONS:**

**Depression** defined as"a negative affective state, ranging from unhappiness and discontent to an extreme feeling of sadness, pessimism, and despondency, that interferes with daily life. Various physical, cognitive, and social changes also tend to co-occur, including altered eating or sleeping habits, lack of energy or motivation, difficulty concentrating or making decisions, and withdrawal from social activities. It is symptomatic of a number of mental health disorders".(APA dictionary)

**Anxiety** definition as, "an emotion characterized by apprehension and somatic symptoms of tension in which an individual anticipates impending danger, catastrophe, or misfortune. The body often mobilizes itself to meet the perceived threat: Muscles become tense, breathing is faster, and the heart beats more rapidly. Anxiety may be distinguished from fear both conceptually and physiologically, although the two terms are often used interchangeably. Anxiety is considered a future-oriented, long-acting response broadly focused on a diffuse threat, whereas fear is an appropriate, present-oriented, and short-lived response to a clearly identifiable and specific threat". (APA Dictionary)

**Stress** defined as,"the physiological or psychological response to internal or external stressors. Stress involves changes affecting nearly every system of the body, influencing how people feel and behave. For example, it may be manifested by palpitations, sweating, dry mouth, shortness of breath, fidgeting, accelerated speech, augmentation of negative emotions (if already being experienced), and longer duration of stress fatigue. Severe stress is manifested by the general adaptation syndrome. By causing these mind–body changes, stress contributes directly to psychological and physiological disorder and disease and affects mental and physical health, reducing quality of life. See also chronic stress. [first described in the context of psychology around 1940 by Hungarian-born Canadian endocrinologist Hans Selye (1907–1982)."(APA Dictionary)

**Suicide** definied,"the act of intentionally taking one’s own life. Death by suicide can occur in the context of a major depressive episode, but it may also occur as a result of

substance use or other physical or mental disorders. It can manifest independently of any psychiatric disorder, sometimes without warning signs, particularly as a result of stressful circumstances such as prolonged bereavement, bullying, financial difficulties, or declining health. See also attempted suicide; passive suicide."(APA Dictionary)

**Suicidal ideation**, "is the thoughts about or a preoccupation with killing oneself, often as a symptom of a major depressive episode. Most instances of suicidal ideation do not progress to attempted suicide".(APA Dictionary)

**Suicidality,** "is the risk of suicide, usually indicated by suicidal ideation or intent, especially as evident in the presence of a well-elaborated suicidal plan".(APA Dictionary)

**Suicidal behaviour**," refers to actions taken by an individual that are intended to cause their own death. This includes suicidal ideation (thoughts about suicide), suicide attempts (self-injurious behavior with intent to die but not resulting in death), and completed suicide".(APA Dictionary)

**Youth** refers to "the period between childhood and adulthood, typically characterized by growth, development, and the transition to maturity. It often includes the teenage years and early twenties, representing a time of energy, learning, and self-discovery"( Oxford Dictionary).

**Mental Health** is " a state of well-being where an individual realizes their abilities, copes with life's stresses, works productively, and contributes to their community"(WHO).

**Suicide Attempt** defined as "A self-directed, potentially injurious behavior with intent to die as a result of the behavior. A suicide attempt might not result in death or injury.(National Institute of Mental Health); "A non-fatal act in which an individual deliberately initiates a behavior (such as self-injury or ingestion of a substance) with the intention of causing death, but which does not result in death" (WHO).

**Interrupted suicide attempt** refers to "a situation where an individual initiates a suicidal act but is stopped by someone or something external to the individual before actually carrying out the act." (World Health Organization)

**Self-interrupted attempt,** or **Aborted suicide attempt**, "refers to a situation where an individual initiates actions or plans to harm themselves, but they choose to stop themselves before actually carrying out the intended self-destructive behavior."(loinc.org)

**Preparatory acts or behavior** are defined as "actions or preparations towards an imminent suicide attempt, including anything beyond verbalization or thought, such as assembling a method or preparing for death." (loinc.org)

**Lethality** refers to "the degree of dangerousness or likelihood of death associated with a particular course of action, often used when comparing methods of suicide." (APA dictionary)

**METHODS:**

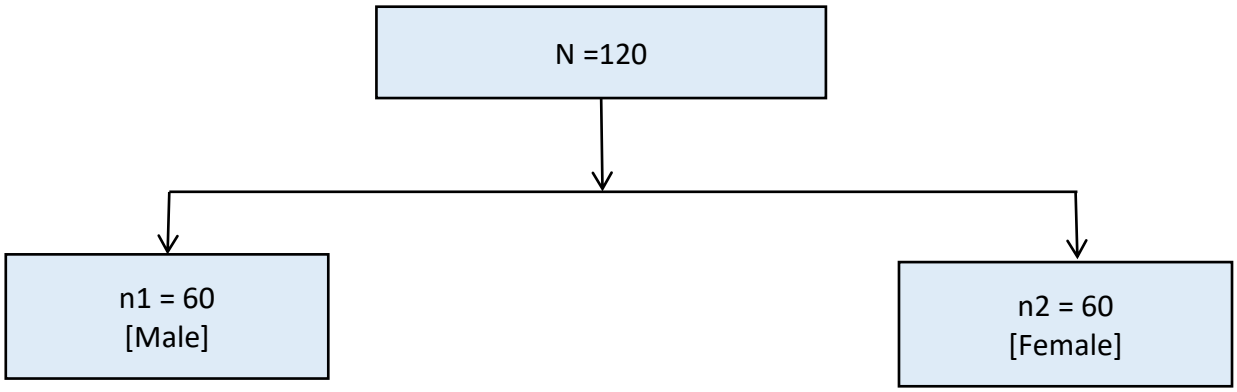
**SAMPLE:**

The purposive sampling technique was used for the present study. A total number of 150 participants were approached, among which 130 participants signed the consent form and participated in the study. All participants completed the DASS-21 questionnaire, while some participants refused to complete the Columbia Asia Suicide Severity Rating Scale, citing discomfort with the nature of the questions.Out of the 130 participants, 10 were excluded due to either incomplete responses or not meeting the inclusion criteria. From this pool of data, a total of 120 usable data sets were selected for the present study.The total sample was divided on the basis of gender (male and female) within the 15–24 years age range. All participants were selected from Kolkata and its surrounding areas.

The number of participants were assigned to each group based on gender(male and female) are as follows:

Male youth: 60

Female youth:60




The participants were selected on the basis of the following inclusion and exclusion criteria:

**Inclusion criteria:**

- Participants must identify as male or female
- Age range between 15 to 25 years
- Belong to middle to high socio-economic status
- Must have basic understanding of English
- Be willing to provide informed consent

- Be able to communicate clearly with a clinician for the Columbia Suicide Severity Rating Scale
- Be mentally and physically capable of participating in a face-to-face session lasting approximately 30–45 minutes
- Be either students, employed, or unemployed but not diagnosed with a clinical disorder.
- Have no history of psychiatric diagnosis
- Be residing in Kolkata or nearby areas during the time of data collection

**Exclusion criteria:**

- Identified outside the male or female gender binary (to maintain research scope consistency)
- Below 15 years or above 24 years of age
- Those who have no understanding for english language
- Participants with incomplete or missing data
- Identified as non-binary, transgender, or other gender identities (not due to bias, but for research scope specificity—this should be ethically clarified)
- Had a diagnosed psychiatric or Physical illness
- Were currently undergoing psychiatric treatment or therapy
- Had a history of major neurological disorders or cognitive impairments
- Were unwilling to participate or withdrew consent,Provided incomplete or inconsistent responses in the questionnaires
- Had acute emotional distress at the time of the interview that required immediate clinical intervention
- Those who belongs from psychology field

The participants who were selected for present study are referring as "subjects" here.

## DESCRIPTION OF THE TOOLS:

### I. **Demographic details**

An information schedule was used to gather demographic details - name, age, gender, address, education level, socio economic status, residence (Rural/Urban), occupation,

Maritial status, Mother tongue, Religion, Family Type, Number of Family Members, Family income.

II. **Depression Anxiety Stress Scales- Short Form (DASS-21)**

**Description:**

Originally developed by Syd Lovibond and Peter Lovibond at the University of New South Wales in 1995, The Depression, Anxiety and Stress Scale (DASS-21) is a quantitative measure of distress. It examines three areas: depression, anxiety, and stress. Each of the three subscales includes seven items.

In the area of depression, the scale measures levels of hopelessness, worthlessness,devaluation of life, self-deprecation, lack of interest, anhedonia, and inertia.

In the area of anxiety, it measures autonomic arousal, situational anxiety, skeletal muscle effects and situational, subjective experience of anxious affect.

In the area of the stress assess difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable and impatient. The tool comprises 21 items selected from the original 42-item scale, based on their strong psychometric properties and factorial strength in measuring depression, anxiety, and stress domains.

**Administration:**

This is a self-administering test. Subjects are asked to rate each item on a 4-point scale based on what they have experienced during the past week. The rating scale is as follows:

0 Did not apply to me at all

1 Applied to me to some degree, or some of the time

2 Applied to me to a considerable degree, or a good part of time

3 Applied to me very much or most of the time

**Scoring:**

Each of the three scales (Depression, Anxiety, and Stress) contains 7 items. Scores for each sub-scale are calculated by summing the responses for the relevant 7 items, and then multiplying the total score by 2 to maintain consistency with the original DASS-42 scale.

The resulting scores categorize the severity of depression, anxiety, and stress based on standard cutoff ranges (e.g., normal, mild, moderate, severe, extremely severe), as provided in the DASS manual.

**Instructions:**

Subjects are instructed to read each statement carefully and select the number (0–3) that best reflects how much the statement applied to them over the past week. They are encouraged to respond honestly and not overthink their answers. There are no right or wrong answers.

**Psychometric Properties:**

**Reliability:**

Studies consistently show high internal consistency reliability for the DASS-21, indicating that the items within each subscale (depression, anxiety, and stress) are measuring the same underlying construct.Cronbach's alpha values for the subscales range from 0.74 to 0.93 where the realiability score of the three subscales varied from 0.81 (Depression), 0.90 (Anxiety) to 0.92 (Stress),

**Test-Retest Reliability:**

The DASS-21 has shown satisfactory test-retest reliability, meaning that scores tend to be consistent over time.Test-retest reliability coefficients over a two-week interval range from 0.71 to 0.81 for the Depression subscale, 0.74 to 0.81 for the Anxiety subscale, and 0.81 to 0.89 for the Stress subscale.

**Validity:**

The DASS-21 demonstrates good construct validity, and convergent validity, correlating well ( ranging from 0.60 to 0.80) with other established measures of depression and anxiety (e.g., Beck Depression Inventory, State-Trait Anxiety Inventory) The three-factor structure (depression, anxiety, stress) has been supported through factor analysis in multiple cultural contexts, including within Indian samples and strong criterion validity effectively distinguish between populations.

**III. Columbia Suicide Severity Rating Scale (C-SSRS)**

**Description:**

The Columbia Suicide Severity Rating Scale (C-SSRS) was developed by Kelly Posner and her colleagues at Columbia University, in collaboration with researchers from the University of Pennsylvania, University of Pittsburgh, and New York

University, with support from the National Institute of Mental Health (NIMH). It is a structured clinical tool designed to assess the full range of suicidal ideation and behavior. The scale is internationally recognized and widely used in both clinical practice and research for risk assessment, suicide prevention, and monitoring.

The C-SSRS examines Suicidal Ideation, intensity of ideation

Suicidal Behavior: Actual, aborted, and interrupted suicide attempts, as well as preparatory behavior/acts.

Lethality: Actual and potential lethality/medical damage and the intensity of intent

**Administration:**

The C-SSRS is conducted face-to-face by a trained clinician. The clinician asks a set of structured questions about suicidal thoughts and behaviors, and the subject responds verbally. The clinician records the answers on the form. The interview takes about 10 to 20 minutes and is done in a private and supportive setting.

**Scoring**:

Scoring includes both Yes/No responses and severity/intensity ratings. Suicidal ideation is rated on a 5-point scale as follows:

Wish to be dead

Non-specific active suicidal thoughts

Suicidal thoughts with method (no specific plan)

Suicidal intent without specific plan

Suicidal intent with plan and method

Suicidal behavior is classified by whether an actual, interrupted, or aborted attempt occurred, along with lethality rating and intent assessment. These scores assist in determining the level of suicide risk.

**Instruction:**

The clinician explains the purpose of the interview, maintains a supportive and non-judgmental environment, and reads each question clearly. Subjects are encouraged to answer honestly, and clinicians provide clarifications if needed—without leading or

influencing responses. The form is filled out by the clinician based on the subject's verbal responses.

**Psychometric Properties:**

**Reliability:**

The C-SSRS has shown excellent inter-rater reliability and test-retest reliability. Studies report intraclass correlation coefficients (ICCs) above 0.80, indicating high consistency in scoring across different raters and over time.

**Validity:**

The scale has strong convergent and predictive validity. It correlates well with other established measures of suicidal ideation and behavior and has been found effective in predicting future suicidal events. It is validated across clinical and non-clinical populations, including adolescents and young adults.

**PROCEDURE FOR DATA COLLECTION:**

All the participants were contacted personally and rapport were established. Consent forms were signed.Consent forms were signed. They were given a briefing about the aim of present study. Instructions were given according to the used questionnaire. They were assured that their information would be kept confidential and used only for research purpose, so they were requested to be open and honest in their responding , after that scales were administered and data were collected.

**STATISTICAL ANALYSIS:**

For the data analysis purpose of the present study, Jamovi software, version 2.6.26 was used, in which descriptive, inferential and correlation analysis were made according to the decision rules for testing the null hypothesis. In the first phase Normality of the distribution, Mean, median, mode and SD were calculated. As the Shapiro-wilk test showed significant deviation from normality,Non parametric test was used.

In second phase, the data were subjected to Mann Whitney U test to find the significant difference between male and female youth on the levels of depression, anxiety, stress, suicidal ideation\,intensity of ideation, suicidal behaviour, actual lethality, potential lethality of suicide attempt. No significant differences were found.

Lastly, Spearman's rho correlation was done to find out the direction of relationship between depression,anxiety, stress, suicidal ideation, suicidal behaviour. Significant positive correlation was found.

# Chapter IV

# RESULTS

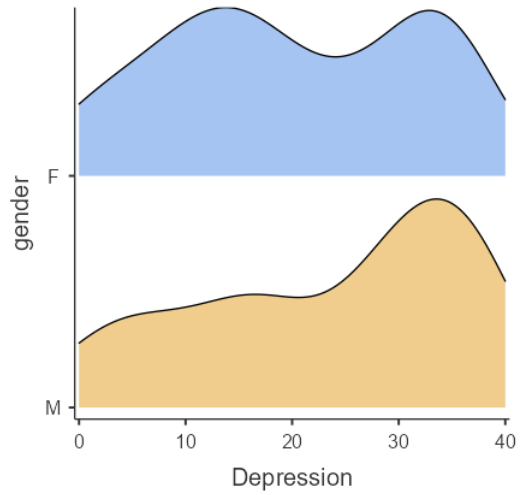
## TABLE NO 1: RESULTS ON NORMALITY OF DISTRIBUTION

| | Gender | Depression | Anxiety | Stress | Suicidal Ideation | Intensity of Ideation | Suicidal Behaviour | Actual Lethality of Suicide Attempt | Potential Lethality of Suicide Attempt |
|---|---|---|---|---|---|---|---|---|---|
| **N** | **F** | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 |
| | **M** | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 |
| **Mean** | **F** | 20.1 | 20.4 | 20.1 | 1.37 | 1.22 | 0.683 | 0.250 | 0.217 |
| | **M** | 23.5 | 21.0 | 21.1 | 1.67 | 1.40 | 0.867 | 0.250 | 0.217 |
| **Skewness** | **F** | -0.0728 | 0.0745 | 0.150 | 0.939 | 1.12 | 1.62 | 1.95 | 1.41 |
| | **M** | -0.504 | -0.140 | -0.0697 | 0.708 | 1.03 | 1.31 | 1.95 | 1.96 |
| **Std. error skewness** | **F** | 0.309 | 0.309 | 0.309 | 0.309 | 0.309 | 0.309 | 0.309 | 0.309 |
| | **M** | 0.309 | 0.309 | 0.309 | 0.309 | 0.309 | 0.309 | 0.309 | 0.309 |
| **Kurtosis** | **F** | -1.27 | -1.22 | -1.20 | -0.718 | -0.323 | 1.00 | 3.14 | -0.0105 |
| | **M** | -1.11 | -1.33 | -1.44 | -1.11 | -0.585 | 0.0205 | 3.14 | 3.16 |
| **Std. error kurtosis** | **F** | 0.608 | 0.608 | 0.608 | 0.608 | 0.608 | 0.608 | 0.608 | 0.608 |
| | **M** | 0.608 | 0.608 | 0.608 | 0.608 | 0.608 | 0.608 | 0.608 | 0.608 |
| **Shapiro-Wilk W** | **F** | 0.928 | 0.931 | 0.932 | 0.714 | 0.697 | 0.559 | 0.535 | 0.508 |
| | **M** | 0.898 | 0.927 | 0.904 | 0.769 | 0.722 | 0.608 | 0.535 | 0.512 |
| **Shapiro-Wilk p** | **F** | 0.002 | 0.002 | 0.002 | <.001 | <.001 | <.001 | <.001 | <.001 |
| | **M** | <.001 | 0.002 | <.001 | <.001 | <.001 | <.001 | <.001 | <.001 |

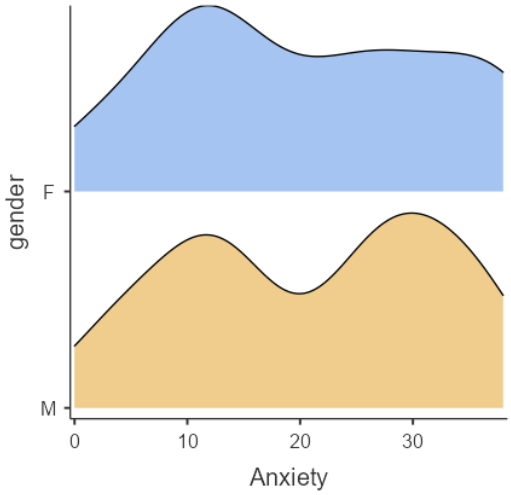
**TABLE NO 1:It is evident from the above Table 1 that Shapiro-Wilk p value is significant at the 0.01 level. The distribution deviates significantly from the normal distribution.**

## GRAPHICAL REPRESENTATION ON NORMALITY OF DISTRIBUTION

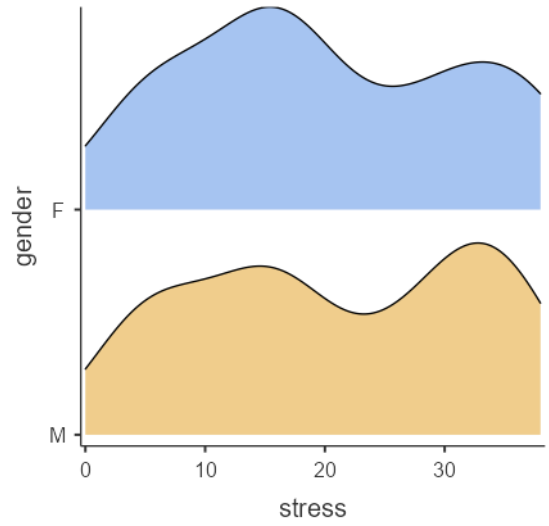
**Depression**



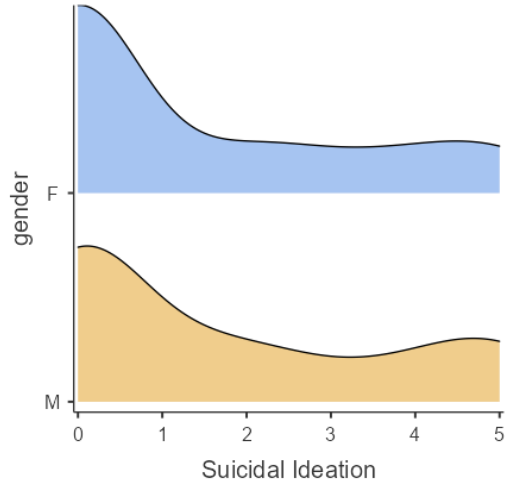

**Anxiety**



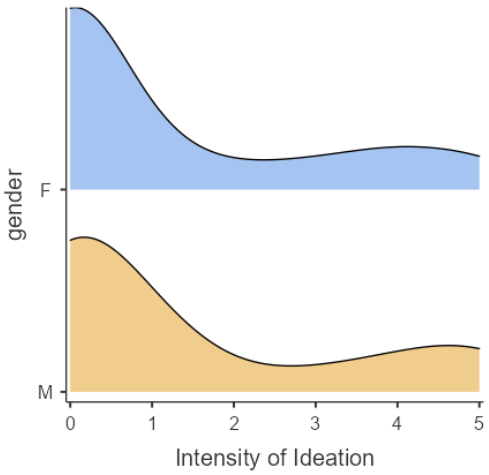

**Stress**



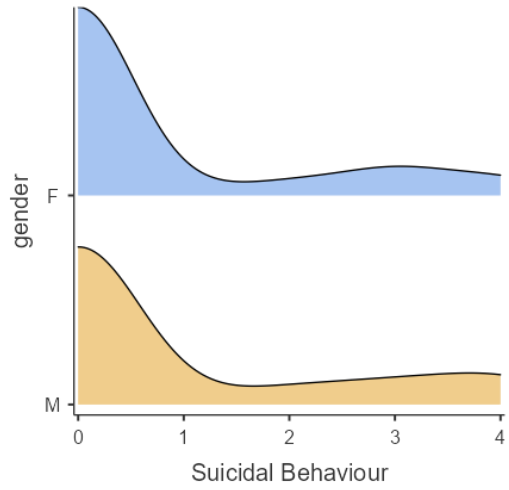
**Suicidal Ideation**



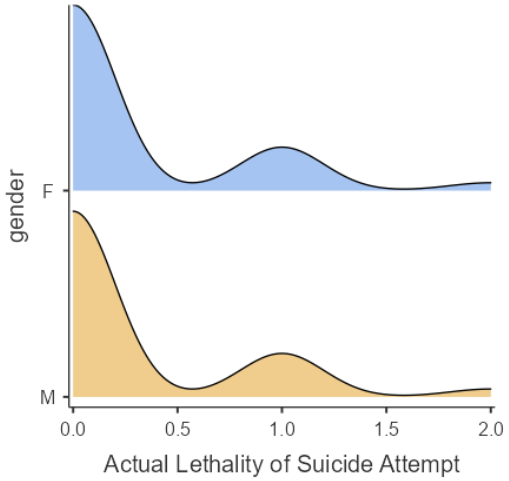

**Intensity of Ideation**



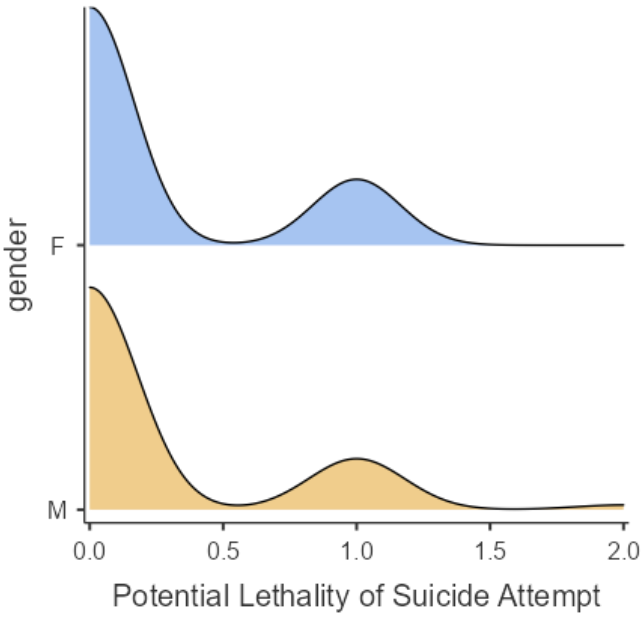

**Suicidal Behaviour**




**Actual Lethality of Suicide Attempt**



**Potential Lethality of Suicide Attempt**



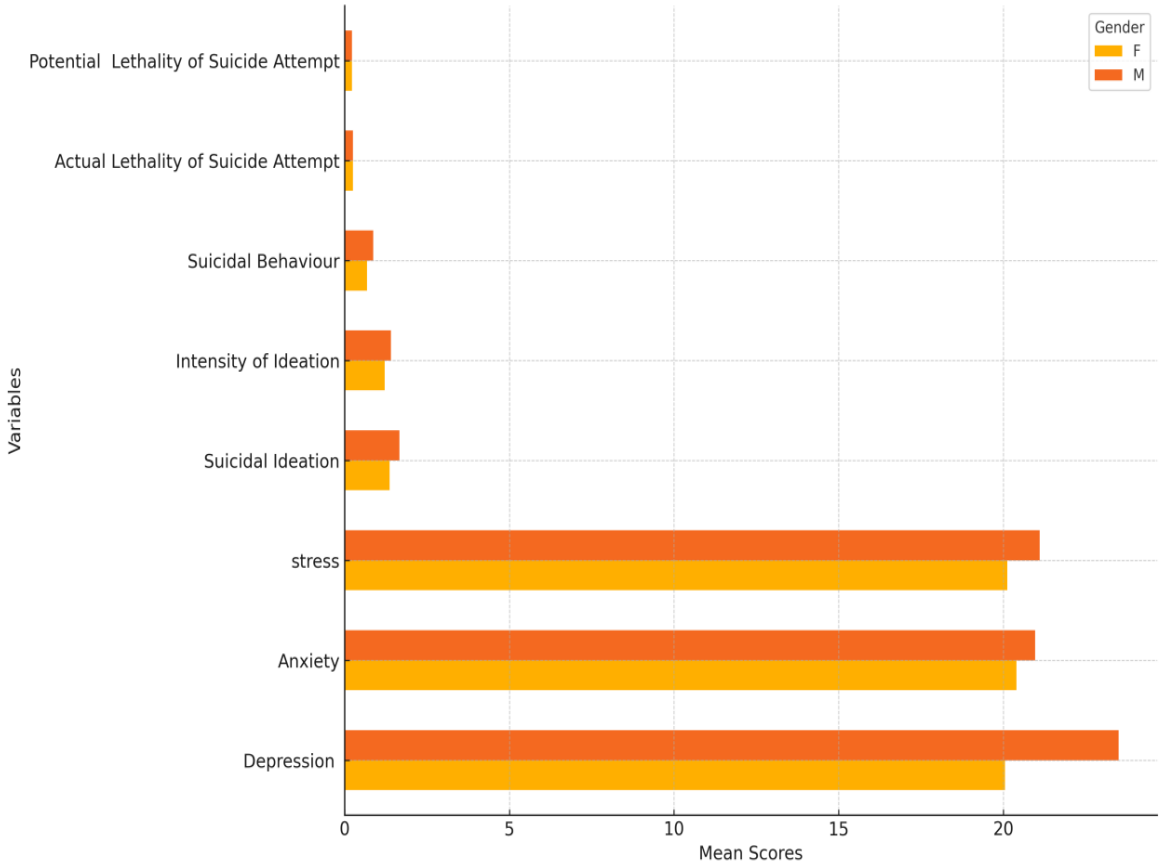
## TABLE NO 2: DESCRIPTIVES STATISTICS TABLE

| | gender | Depression | Anxiety | Stress | Suicidal Ideation | Intensity of Ideation | Suicidal Behaviour | Actual Lethality of Suicide Attempt | Potential Lethality of Suicide Attempt |
|---|---|---|---|---|---|---|---|---|---|
| **N** | **F** | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 |
| | **M** | 60 | 60 | 60 | 60 | 60 | 60 | 60 | 60 |
| **Mean** | **F** | 20.1 | 20.4 | 20.1 | 1.37 | 1.22 | 0.683 | 0.250 | 0.217 |
| | **M** | 23.5 | 21.0 | 21.1 | 1.67 | 1.40 | 0.867 | 0.250 | 0.217 |
| **Median** | **F** | 18.0 | 19.0 | 17.0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **M** | 28.0 | 24.0 | 19.0 | 1.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| **Mode** | **F** | 10.0 | 12.0 | 16.0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| | **M** | 36.0 | 12.0 | 16.0 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| **Standard deviation** | **F** | 11.8 | 11.9 | 11.4 | 1.88 | 1.78 | 1.32 | 0.508 | 0.415 |
| | **M** | 12.4 | 11.4 | 11.6 | 1.96 | 1.88 | 1.48 | 0.508 | 0.454 |

**The above TABLE NO 2 Represents descriptive statistics (mean, median, mode, and standard deviation) comparing depression, anxiety, stress, suicidal ideation, intensity of ideation, suicidal behaviour, actual lethality and potential lethality of suicide attempt among male and female youth.**

## GRAPHICAL REPRESENTATION

**Graphical representation of mean differences on depression,anxiety, stress,suicidal Ideation ,Intensity Of Ideation,Suicidal Behaviour,Actual And Potential lethality of Suicide Attempt Between Gender ( Male and Female)**



**TABLENO 3: RESULTS OF MANN-WHITNEY U TEST**

| Independent Samples T-Test | | | |
|---|---|---|---|
| | | **Statistic** | **p** |
| **Depression** | **Mann-Whitney U** | 1478 | 0.091 |
| **Anxiety** | **Mann-Whitney U** | 1751 | 0.796 |
| **stress** | **Mann-Whitney U** | 1739 | 0.748 |
| **Suicidal Ideation** | **Mann-Whitney U** | 1616 | 0.292 |
| **Intensity of Ideation** | **Mann-Whitney U** | 1665 | 0.436 |
| **Suicidal Behaviour** | **Mann-Whitney U** | 1700 | 0.495 |
| **Actual Lethality of Suicide Attempt** | **Mann-Whitney U** | 1800 | 1.000 |
| **Potential Lethality of Suicide Attempt** | **Mann-Whitney U** | 1777 | 0.864 |
| | | | |

**TABLE NO 3, Represents the result of the Mann-Whitney U test. P values are not significant for any of the variables. Hence, H1 to H8 are rejected at the 0.05 level. There exists no significant mean difference between male and female youth in terms of depression, anxiety, stress, suicidal ideation, intensity of ideation, suicidal behaviour, actual lethality, and potential lethality of suicide attempts.**

**TABLE NO 4: RESULTS ON CORRELATION BETWEEN DEPRESSION, ANXIETY AND STRESS AMONG MALE AND FEMALE YOUTH**

| CORRELATION MATRIX | | | |
|---|---|---|---|
| | | Anxiety | Stress |
| Depression | Spearman's rho | 0.861** | 0.851** |
| | df | 118 | 118 |
| | P-value | < .001 | < .001 |

****significant at 0.01 level.**

**Table No 4: Represents the result finding on correlation. P values are significant for all the variables. Hence, H9 is accepted at the 0.01 level. There is a significant relationship between depression, anxiety, and stress among male and female youth.**

**TABLE NO 5: RESULTS ON CORRELATION BETWEEN SUICIDAL IDEATION AND SUICIDAL BEHAVIOUR AMONG MALE AND FEMALE YOUTH**

| CORRELATION MATRIX | | |
|---|---|---|
| | | Suicidal Behaviour |
| Suicidal Ideation | Spearman's rho | 0.828** |
| | df | 118 |
| | P-value | < .001 |

****significant at 0.01 level.**

**Table No 5: Represents the result finding on correlation. P value is significant for both of the variables. Hence, H10 is accepted at the 0.01 level. There is a significant relationship between suicidal ideation and suicidal behaviour among male and female youth.**

# Chapter V

# DISCUSSION

## DISCUSSION

**Discussion on normality of distribution (Table No 1)** indicates that Shapiro-Wilk p value is significant at the 0.01 level. The distribution deviates significantly from the normal distribution.This non-normal distribution could be because of the sensitive and personal nature of the variables studied. The variables depression, stress, and suicidal thoughts often vary greatly between individuals and may not follow a typical bell-shaped curve. Also, the skewness and kurtosis values in the table no 1 shows that the data is not symmetrical and does not match the pattern of normal distribution.

As a researcher, while conducting the survey it has been observed that the Shapiro-Wilk p-value is less than 0.01 level, which indicates that the results are statistically important and the data is different from normal distribution pattern.Variables like depression, stress, suicidal ideation and suicidal behaviour are very personal and emotional, and the experience are totally individualized. The past research findings reveals that in the general population, mental health problems like depression and suicidal ideation do not usually follow a normal curve. Most people may report low symptoms, while a smaller group reports very high symptoms. The same pattern found here also, especially in suicidal variables, where most participants had low scores, but a few had very high scores, making the data non-normal. Another reason of this findings could be the sensitive nature of the topics. When people are asked about mental health or suicidal thoughts, some of individual are not answer honestly and they might have very different personal experiences, which causes the results to be uneven.Some people might feel very low, while others may not feel much at all. That's why results shows some scores are very high and many are very low or zero. Furthermore, data taken from the normal distribution because of the sensitive issues, inspite of making good rapport in first meet some of the individual not feel comfortable sharing personal issues or they may not even fully understand their own feelings. That could also affect how the answers came out. This results are natural for this kind of study and they help remind that each person's mental health journey is unique and Non parametric test used (the Mann-Whitney U test) to compare groups more fairly.

Those past reserch results came out same, Kessler et al. (2003) in the National Comorbidity Survey found that mental health disorders are unevenly distributed in the general population and large number of people show no symptoms while a few face

intense difficulties. Similarly, Joiner (2005) in his work on suicide stated suicidal ideation and behaviours are often rare but intense, leading to non-normal distributions.In the past study of Patel et al. (2007) revealed that in developing countries among youth populations, mental health issues often go unnoticed and untreated, causing the data to be more unpredictable and not follow the expected "normal" shape. So this current findings is not very surprising. Each individual experiences emotional pain differently, and mental health is purely personal. The sensitive nature of the topics like suicidal ideation and behaviour makes it even harder to get perfectly balanced responses. Some people might not feel comfortable sharing, while others may have very strong experiences that raise the scores sharply, as a researcher sees the non-normal distribution not as a problem, but as a natural characteristic of mental health data and adjusts the analysis methods accordingly to ensure the results are still meaningful and reliable.

**Discussion on Descriptive statistics (Table No 2 )** Represents descriptive statistics (mean, median, mode, and standard deviation) comparing depression, anxiety, stress, suicidal ideation, intensity of ideation, suicidal behaviour, actual lethality and potential lethality of suicide attempt among male and female youth which shows that Males report higher means than females on depression (M = 23.5 vs. 20.1), anxiety (M = 21.0 vs. 20.4), stress (M = 21.1 vs. 20.1), and suicidal ideation (M = 1.67 vs. 1.37), though the differences were not statistically significant.The results show that male participants generally report higher means than female participants for depression, anxiety, and stress, while also indicating more intensity in ideation and suicidal behavior. However, both groups report the same mean scores for actual and potential lethality of suicide attempts.

While conducting the survey it has been observed that Males may express distress in ways that differ from females. Men tend to externalize their distress through behaviors like aggression , while women often internalize their distress, leading to higher rates of depression and anxiety. The differences in mean scores of depression, anxiety, and suicidal ideation could be attributed to this disparity in emotional expression.Moreover, the similarity in the lethality of suicide attempts could suggest that both genders, despite differences in emotional expression, experience same levels of hopelessness when contemplating suicide. Another possible reason for this

difference could be that male often find it harder to express emotions openly, which can lead to their feelings building up over time.

Some past research reveals that, male may not talk about their mental health as much, but that doesn't mean they aren't deeply affected.Interestingly, both male and female groups had very similar scores when it came to the lethality of suicide attempts. This indicates that even though the emotional symptoms might appear slightly stronger in males, both genders are equally vulnerable when it comes to real danger. That's a powerful reminder that mental health support should be for everyone, regardless of gender. This result shows that while emotional symptoms may vary a little between male and female, every young person deserves understanding, support and a safe space to express their struggles.Recent studies of Sweeting et al. (2010), indicates that gender gaps may be decreasing due to changing social dynamics and increasing emotional expression in males. However, the visibility of emotional struggles on social media may have made it more socially acceptable for young men to address distress (Twenge, Joiner, Rogers, & Martin, 2018). This could explain the comparable or even slightly higher self-reported distress levels in males found in this study.The core of the data encourge to listen to all youth with empathy without any gender bias because behind every number, there is always a story. Moreover, the mode and median values indicate that both male and female youth tend to have a distribution skewed toward lower levels of suicidal behavior, with many reporting minimal or no ideation and behavior. The standard deviations are relatively large, indicating variability in responses, yet the lack of significant gender differences suggests that both groups experience distress in a similar manner.Female slightly higher stress scores could reflect gendered societal pressures for example social expectations related to body image, relationships, or academic success, although this finding is not statistically significant indicating that gender does not seem to significantly affect the intensity or severity of suicidal ideation or the potential lethality of suicide attempts.

**Discussion on difference between male and female with respect to…….. (Table No 3)** Represents the result of the Mann-Whitney U test where the P values are not significant for any of the variables. Hence, H1 to H8 are rejected at the 0.05 level. There exists no significant mean difference between male and female youth in terms of depression, anxiety, stress, suicidal

ideation, intensity of ideation, suicidal behaviour, actual lethality, and potential lethality of suicide attempts.

The Mann-Whitney U test help to check if there are any significant differences between male and female youth in terms of depression, anxiety, stress, suicidal ideation, intensity of ideation, suicidal behaviour, and the lethality of suicide attempts. The results show that none of the differences are statistically significant (all p-values are greater than 0.05). This means that, the average scores for males and females may look slightly different, these differences are not strong enough to be considered meaningful from a scientific point of view. One possible reason of no significant gender difference was found could be that both male and female youth are experiencing similar levels of emotional and psychological difficulties in today's world. With increasing academic pressure, social media influence, and lack of mental health awareness, both genders might be equally vulnerable.

The past studies reveals that the gender differences in mental health symptoms are decreasing over time. In the past reserch by Hyde et al. (2008) suggested that gender differences in depression are small and may not always appear in all age groups or cultures. Another study by Twenge and Nolen-Hoeksema (2002) also showed that in modern societies, young males and females report similar levels of psychological stress and distress.

As a researcher, this outcome is meaningful because it directly challenges the common assumption that gender differences are substantial in the mental health outcomes of youth. First, it’s possible that males are feeling more pressure to hide their emotions, which could build up inside and show in higher scores for depression and stress. On the other hand, females might be more likely to express or talk about their feelings, which could sometimes help in reducing the severity of those feelings.Also, in many cultures, males are often taught to “stay strong” or “be tough,” and this can make them suppressed their emotions. Over time, this might lead to higher mental strain, which could be why their average scores seem a bit higher. But the fact that the median and mode values for both groups are quite close or even the same in some areas shows that emotional challenges are common to both males and females they just show it in different ways. These results reminds that mental health doesn’t choose gender and it is totally individualized. It affects everyone and both males and females need love, support, and a safe space to talk about what they’re going through. These small differences in scores are important, but they also show

that youth as a whole are going through a lot and our focus should be on helping all of them, no matter their gender, the lack of difference may also be due to cultural factors, where both genders may express emotional problems differently or may not report them openly. It is also possible that support systems or coping strategies are becoming more balanced across genders, reducing the gap in how mental health issues affect them.

**Discussion on the Correlation Between Depression, Anxiety And stress Among Male and Female Youth (Table No 4)** Represents the result finding on correlation, P values are significant for all the variables. Hence, H9 is accepted at the 0.01 level. There is a significant relationship between depression, anxiety, and stress among male and female youth.

The findings show that there is a strong and significant positive correlation between these three variables (with correlation values of 0.861 and 0.851, and p-values less than 0.01level). This indicates that as depression increases, anxiety and stress also increase. These results support the idea that emotional problems in youth are often interconnected.

While conducting the survey it has been observed that Today's youth are under a lot of pressure from studies, family expectations, relationships, social pressure and even social media. When someone feels low or hopeless,worthless , they often also feel worried about their future (anxiety), and their body and mind stay tense or overwhelmed (stress). These feelings are deeply connected, and one can easily trigger the others.

From past research studies by Lovibond & Lovibond (1995) using the DASS 21 scale have shown that depression, anxiety, and stress are highly related psychological states. More recent studies also confirm that when young people face one of these issues, they are more likely to experience the others too. Studies have also shown that these three emotional states don't usually come alone they often appear together, forming what's sometimes called a "trio of emotional distress." So, it's not surprising that this study found the same pattern.This result help us to understand how important it is to care for the mental well-being of youth, without any gender bias. Helping them manage even one of these emotions like reducing stress, help to cope with stressors of life could also make a positive impact on anxiety and depression. That's why early

support and awareness are so important, very high numbers showing that depression, anxiety and stress move together in our group of youth people.

While conducting this survey it has been observed that the need to treat these problems together rather than separately. That's why current findings reveals that there is a strong and significant positive correlation between these three variables (with correlation values of 0.861 and 0.851, and p-values less than 0.001). This means that as depression increases, anxiety and stress also increase , These results support the idea that emotional problems in youth are often interconnected.

**Discussion on correlation Between Suicidal Ideation and Suicidal Behaviour Among Male and Female Youth (Table No 5)** Represents the result finding on correlation. P value is significant for both of the variables. Hence, H10 is accepted at the 0.01 level. There is a significant relationship between suicidal ideation and suicidal behaviour among male and female youth, indicating a strong and statistically significant relationship between the two variables.

The past research reveals that the connection between thoughts of suicide and actual suicide attempts or behaviour. Previous studies, such as those by Joiner (2005) and O'Connor & Nock (2014), have established that individuals who experience intense suicidal ideation are at a higher risk of acting on those thoughts, translating into suicidal behaviour. This correlation can be explained by the fact that both ideation and behaviour are tied to underlying psychological conditions like depression, anxiety, and stress, as shown in earlier tables results.Table 5 shows that young people who have stronger thoughts of suicide are also much more likely to act on those thoughts so much so that the link between "thinking about it" and "doing it" is much strong.

The table presents a significant correlation between suicidal ideation and suicidal behavior ($\rho = 0.828$, $p < .001$), H10 is accepted at the 0.01 level.This is consistent with a strong body of research demonstrating that suicidal ideation is one of the strongest predictor of suicidal behavior (Joiner, 2005; Nock et al., 2008). Klonsky & May (2015) proposed the ideation-to-action framework, which suggests that while many individuals may think about suicide, only a subset progress to action, influenced by factors like acquired capability, impulsivity, or access to means. The strong correlation found in this study suggests that within this youth population, the transition from thoughts to behavior may be less obstructed, warranting immediate intervention at the ideation stage. It also shows that this connection is equally strong

for both males and females, so our prevention efforts must focus on any youth expressing suicidal thoughts, regardless of gender.

While gender differences in mental health issues have been widely reported historically, this study suggests these differences may be decreasing among youth. These results reflect a potential cultural and generational shift, where both male and female youth are equally affected by depression, anxiety, stress and suicidal tendencies. The strong inter correlations among emotional distress variables and between ideation and behavior also stress the urgency of early identification and comprehensive mental health programs in schools and communities.

Numerous earlier studies that gender would play a significant role in the expression of depression, anxiety, stress, and suicidal ideation among youth. Traditionally, research has reported that females are more prone to internalizing disorders such as depression and anxiety (Nolen-Hoeksema, 2001; Piccinelli & Wilkinson, 2000), while males often exhibit higher rates of suicide completion (CDC, 2017).

Moreover, from the current findings, it became evident that gender differences were not statistically significant across all variables measured. This challenged my initial assumptions and led me to reflect on changing societal norms, improved mental health awareness, and greater emotional openness among young males. It appears that emotional distress may now be experienced and expressed similarly across genders, possibly due to the effects of social media, peer influence, and the breakdown of traditional gender stereotypes.Furthermore, the strong correlations between depression, anxiety, and stress reinforced the idea that these emotional conditions often co exist and should be addressed holistically. The strong relationship between suicidal ideation and behavior further focus on the critical need for early psychological screening and intervention, especially in educational settings where youth spend most of their time.

This study define the broad spectrum of youth mental health, one where gender is no longer the defining factor it once was. Instead, the shared emotional burden across both genders calls for inclusive, non-stereotyped mental health strategies. As a researcher, While conducting the survey it has been observed that the need to focus less on traditional gender-based assumptions and more on individual psychological needs and social factors affecting all youth, regardless of gender.The lack of significant gender differences in the study could also reflect evolving societal norms.

Increased mental health awareness and reduced stigma may encourage more open expression of emotional struggles among males, leading to reporting levels comparable to females. Additionally, the pervasive influence of social media and the shared challenges of modern adolescence such as academic pressures and economic uncertainties may contribute to a convergence in mental health experiences across genders.

Find similar studies where same results have been found:

Those studies Indicating that No Significant Gender Differences in Kerala Youth Mental Health Studies reveals youth in Kerala assessed mental health using the Mental Health Inventory (MHI). The results revealed no significant gender differences in overall mental health scores. While males scores slightly higher general positive affect, the overall mental health status was comparable across genders. This suggests that both male and female youths in Kerala experience similar levels of mental well-being.

Another research conducted on urban adolescents in Maharashtra found no significant association between gender and depression scores. The study highlighted that both male and female in urban settings exhibits similar levels of depression, indicating a diminishing gender gap in mental health issues among urban youth.

A study involving undergraduate students in Andhra Pradesh assessed depression, anxiety, and stress levels using the DASS-42 questionnaire. The result indicated that while females had higher depression scores, there were no significant gender differences in anxiety and stress levels. This suggests that certain psychological parameters may not differ markedly between genders in this demographic. An investigation into the mental health and self-esteem of school children in Jammu City revealed no significant gender differences in self-esteem levels. Although boys had slightly higher mean scores, the differences were not statistically significant, indicating comparable self-esteem levels across genders in this age group. Another studies focused on suicidal ideation and behavior in Chennai among youth aged 16-19 found no significant gender differences in the rates of suicidal ideation, attempts, or the severity of those attempts. The study attributed these findings to similar life stressors affecting both male and female youth, including academic pressures and familial expectations. The study concluded that mental health interventions for suicide prevention should address gender-neutral approaches.

A large-scale survey conducted among urban youth in Mumbai revealed that although there were some slight variations in depression scores between genders, the overall findings showed no significant gender differences in the prevalence of anxiety, stress, or suicidal ideation. The study suggested that the shared stressors of urban life, including exposure to digital media and academic pressures, contribute to similar mental health outcomes across genders.

Implications for present Research studies collectively support the traditional gender disparities in mental health parameters are diminishing among Indian youth. Factors such as increased mental health awareness, changing societal norms, and greater emotional openness among males may contribute to this trend.These studies collectively suggest that gender differences in mental health outcomes may be diminishing among youth, particularly due to common social stressors that affect both genders similarly. The findings from this research, which also indicate no significant gender differences in depression, anxiety, stress, and suicidal ideation. It define the importance of gender neutral mental health interventions, considering that both male and female youth today face shared emotional and psychological challenges.

The Gender Similarities Hypothesis, proposed by Janet Hyde, suggests that males and females are more similar than different across most psychological variables. This theory challenges the common perception of significant psychological differences between genders.

Current results showing no significant gender differences across depression, anxiety, stress, and suicidal behavior align closely with this theory. Hyde (2005) reviewed 46 meta-analyses and found that 78% of gender differences across psychological traits were either small or close to zero. Thus, this study findings support the idea that mental health symptoms in youth are not strongly determined by gender and modern adolescents may experience similar psychological burdens regardless of sex.

Tripartite Model of Anxiety and Depression proposed by Clark & Watson, 1991, This model explains the comorbidity of anxiety and depression by proposing three components:Negative Affect (NA): common to both anxiety and depression,Positive Affect (PA): low PA is specific to depression,Physiological Hyper Arousal (HA): specific to anxiety.

This study result revealed strong correlations between depression, anxiety, and stress, which this model predicts. It suggests that youth across both genders may share a common core of emotional distress, rooted in high negative affect.

Ideation-to-Action Framework of Suicidal Behavior explained by Klonsky & May in 2015 distinguishes between having suicidal thoughts (ideation) and acting on them (attempts or behavior). It argues that the transition from ideation to behavior depends on additional factors such as acquired capability, impulsivity, or access to means. This studies results found a strong correlation between suicidal ideation and behavior, but no gender difference in either. This aligns with the theory, suggesting that both genders may experience similar pathways from thoughts to actions when certain risk factors are present. It supports the idea that intervention must target all youth, not just based on gender.

Cognitive Appraisal Theory proposed by Lazarus & Folkman in 1984 explained that stress is not directly caused by external events, but by how individuals appraise (interpret) those events. There are two main types of appraisal:

Primary appraisal: Evaluating if an event is a threat or challenge.

Secondary appraisal: Assessing one's ability to cope with the event.

This theory explains why both males and females may report similar levels of stress, anxiety, and depression, if they perceive and interpret life challenges similarly, regardless of gender, their emotional responses will also be similar. As societal norms become more balanced, the way youth appraise academic pressure, social dynamics, or future uncertainty might also become more uniform across genders.

Beck's Cognitive Theory of Depression proposed by Beck, 1967) suggests that depression results from negative thought patterns—known as the "cognitive triad":Negative view of the self,Negative view of the world,Negative view of the future.

This theory implies that cognitive distortions can occur in anyone, regardless of gender. If both male and female youth are exposed to similar negative thinking due to academic stress, social pressure, or personal insecurities, the resulting depression or anxiety would not differ significantly by gender, as observed in my result. This supports the idea that cognitive factor more than gender drive depression and emotional distress.

Learned Helplessness Theory proposed by Seligman in 1975 which suggest that when individuals repeatedly face uncontrollable negative events, they may develop a sense of helplessness, leading to depression. The person begins to believe that nothing they do can change their situation.

In the present studies shows that Modern youth often face similar stressors, such as competitive education systems, social media pressure, and family expectations. These shared experiences might cause both male and female youth to develop feelings of helplessness, leading to comparable levels of depression, anxiety, or even suicidal thoughts—which explains why no gender differences emerged in my data.

Maslow's Hierarchy of Needs proposed by abraham Maslow in 1943 which explain that humans have a hierarchy of needs, from basic (food, safety) to higher-level (esteem, self-actualization). If lower needs (e.g., emotional security, belonging) are unmet, individuals may develop emotional and psychological problems. Both male and female youth in the study may experience similar deficits in psychological needs, such as emotional support, identity, or belonging—especially in the context of peer pressure or academic failure. This could explain the uniformity in psychological distress regardless of gender.

Erikson's Psychosocial Development Theory developed by Erikson in 1950 which emphasized that during adolescence (Identity vs. Role Confusion stage), youth explore who they are. Failure to develop a strong sense of identity can lead to confusion, low self-esteem, and psychological distress. In present study , If both genders are undergoing identity struggles in a similar way due to globalization, academic stress, or changing family dynamic then it is expected that depression, anxiety and stress would not differ significantly between males and females. This supports my findings of no gender bias in mental health outcomes among youth.

all the above psychological theories and models explain that internal thought processes, learned behaviors, social needs, and identity formation play a major role in emotional well-being. None of these mechanisms are inherently gender-specific, which supports this results showing no statistically significant gender differences in mental health variables.

As a researcher, while seeing the overall results of this study, it becomes clear that several meaningful factors may have influenced the findings. One key factor is emotional vulnerability in youth. Young people often go through intense emotional ups and downs, and their ability to cope with stress, anxiety, and depression may not be fully developed. This emotional intensity can explain why we saw strong connections between depression, anxiety, and stress, as well as between suicidal ideation and behaviour.

Another possible factor is the influence of social and environmental pressures. Today's youth are facing challenges such as academic expectations, family conflicts, peer pressure and the impact of social media. These external pressures can quietly build up and contribute to emotional distress which may lead to mental health struggles or even suicidal thoughts.

Gender differences may also play a role. Although there were no significant differences found between males and females in the levels of depression, anxiety, or suicidal thoughts and behaviour, the way each gender expresses or copes with emotions can differ. Some may internalize their pain, while others might act out more openly.

Moreover, the stigma around mental health may prevent many young individuals from seeking help, even when they are deeply struggling. This could explain why suicidal ideation is so strongly connected with behaviour because without support, these painful thoughts can grow quietly until they result in action.

Lastly, it is important to consider that personal history, trauma, or unresolved emotional wounds could also be influencing factors. Every young person brings their own story and those with a history of abuse, neglect, or family instability may be more likely to experience severe mental health challenges These results remind us how delicate and deeply Youth mental health is shaped by many layers emotions, relationships, environments, and experiences. This study gives us a gentle push to listen more closely, respond more kindly, and build systems of care that truly support young people in their times of need.

# Chapter VI
# CONCLUDING REMARKS

# CONCLUDING REMARKS

## CONCLUSION OF THE STUDY:

The present study was undertaken to explore gender differences in depression, anxiety, stress, suicidal ideation and suicidal behavior among youth. The Study was conducted on 120 participants (60 males and 60 females) from Kolkata and its surrounding areas. Participants were assessed using two standardized psychological tools DASS-21 and the Columbia Suicide Severity Rating Scale (C-SSRS). The analysis of results as stated and discussed in the previous chapters of this report appear to be interesting, and the major trends of finding obtained there from seem to converge on certain points on the basis of which the following conclusion may be drawn:

- There exists no significant difference between male and female youth in respect of depression, anxiety, stress levels.
- There exists no significant difference between male and female youth in respect of suicidal ideation , intensity of ideation, suicidal behaviour.
- There exists no significant difference between male and female youth in respect of actual lethality and potential lethality of suicide attempts.
- There exists a significant positive relationship between depression, anxiety, and stress among both male and female youth.
- There exists a significant positive relationship between suicidal ideation and suicidal behavior among both male and female youth.

## Limitations of the Present Study:

It is common that there is no end in research work because all endings herald new direction, a new beginning. The limitations of the study basically comes from the design, methodology and how the data were collected that influenced the application and the interpretation of the work. It is often said that every research opens the door to further inquiry. The limitations of the present study emerged from various aspects of its design, methodology, and scope.The following aspects may be regarded as the limitations of the study:

1. Due to time constrains compromise had to be made with respect to simple size.
2. The study was limited to a specific geographical area, restricting generalizability.
3. Some participants were uncomfortable answering questions related to suicide.
4. The study exclude individuals identifying outside the male female gender binary, limiting inclusivity.

5. The influence of socio cultural and familial background on mental health was not controlled.
6. The study did not assess coping mechanisms, protective factors, or resilience variables.
7. Academic and occupational pressures, which could influence psychological states, were not measured.
8. The study used a cross-sectional design, which limits the ability to establish causality between variables.
9. The emotional readiness and mental health literacy of participants were not assessed, which could affect response accuracy.
10. The DASS-21 was self-administered, while the C-SSRS was clinician-administered, potentially causing variation in participant disclosure and response consistency.
11. The dual approach self-administered DASS-21 and interview based C-SSRS could result in discrepancies due to differences in perceived privacy and pressure, possibly influencing the openness of responses regarding sensitive issues like suicide.
12. The impact of external factors such as family environment, peer pressure and socioeconomic instability were not directly measured.
13. The potential influence of religion, cultural norms and stigma related to mental health in Indian society was not explored.
14. The study may be affected by response bias, as participants might have under reported or over reported symptoms due to social desirability or personal discomfort.
15. The emotional state of participants during the time of data collection could have temporarily influenced their responses.

**Implication of the Present Study:**

The study area on which the investigation has been conducted has its importance because the group is consisted of Indian youth, who are passing through a crucial phase of emotional, psychological, and social development. The purpose of the study is to assess the difference between male and female youth in respect to their mental health status stress, depression and anxiety, suicidal ideation and behaviour. So, from the result it is seen that there exists no significant difference between male and female youth in terms of depression, anxiety, stress and suicidal ideation and suicidal behaviour, which indicates that both genders are equally vulnerable to emotional and

psychological difficulties. Though several factors are responsible for this such as academic pressure, social expectations, family environment and lack of awareness or support systems. Apart from that, it is noticed that depression, anxiety and stress are highly correlated to each other, and suicidal ideation is strongly linked with suicidal behaviour, which can have a serious impact on the mental health of youth. After investigate all the aspects, it can be said that both male and female youth need equal attention, care, and emotional support to deal with their mental health challenges. Mental health awareness programme are needed in educational institutions and communities to help youth understand their emotions, seek help when needed without any gender bias and reduce stigma. Beside that there is a need to improve mental health status of youth through early diagnosis and treatment, preventive strategies and support systems for both males and females without any gender bias. This Results can guide school counselors and mental health professionals in designing for all gender, develop mental health programs and a need for introducing structured emotional education curriculum in schools and colleges or other professional settings. Parents and caregivers should be made aware that mental health issues affect all youth regardless of gender so that early support can be offered at home and for their better future. Media and online platforms should be adopted to promote youth mental health awareness in gender neutral and culturally sensitive ways. Implement a Community programs which can focus on destigmatizing suicidal ideation and encouraging open conversations about mental health.Governmental and non-governmental agencies can use these findings to develop mental health campaigns targeting youth holistically, rather than based on gender stereotypes.

**Suggestions for Further Research:**

Due to time constraints and other difficulties the study area of the present investigation could not be extended. In today's world, the aspects of the present study (mental health status, suicidal ideation, suicidal behaviour, and the relationship between depression, anxiety, and stress) create a huge impact on the youth population but are not yet investigated adequately in the Indian culture. So, there is enough opportunity for further research. Further research may be taken up in the following areas:

1. Sample can be drawn from different regions of India to get a more comprehensive understanding of youth mental health across cultural backgrounds.

2. Both qualitative and quantitative research methods can be used together to get deeper insight into emotional and psychological experiences.

3. How depression, anxiety and stress develop over time among youth through longitudinal studies can be examined.

4. How academic pressure, peer relationships, and social media influence mental health of youth can be explored.

5. The relationship between family environment and suicidal behaviour among youth can be investigated.

6. Influence of socio-economic background on the mental health status of male and female youth can be studied.

7. How awareness and stigma related to mental health differ among male and female youth can be examined.

8. Role of school and college based mental health interventions in reducing suicidal ideation can be studied.

9. The impact of emotional support systems like friendships and parent child relationships on depression and anxiety can be explored.

10. Influence of cultural beliefs and religious values on the expression and reporting of suicidal thoughts can be studied.

11. Further investigation can be made into gender identity and mental health among non-binary and transgender youth.

12. The effect of early childhood experiences and adverse life events on later emotional well being can be researched.

13. Differences in help-seeking behavior among male and female youth related to psychological distress can be examined.

14. Research can be conducted on the effectiveness of digital mental health platforms and online counseling among young individuals.

15. The mental health problem and coping mechanisms among third gender youth from different parts of india can be studied to create better mental health programmes.

16. Role of emotional intelligence and resilience in managing depression, anxiety, and suicidal ideation can be studied.

17. A comparative study between urban and rural youth regarding mental health awareness and coping styles can be undertaken.

# Chapter VII

# REFERENCES

Abdu, Z., Hajure, M., & Desalegn, D. (2020). Suicidal behavior and associated factors among students in Mettu University, South West Ethiopia, 2019: An institutional based cross-sectional study. *Psychology research and behavior management*, 233-243.

Aldridge, D. (1992). Suicidal behaviour: a continuing cause for concern. *British journal of general practice*, *42*(364), 482-485.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA: American Psychiatric Publishing.

American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.; DSM-5-TR). American Psychiatric Publishing.

American Psychological Association. (n.d.). APA dictionary of psychology. https://dictionary.apa.org/

Beautrais, A. L. (2000). Risk factors for suicide and attempted suicide among young people. *Australian & New Zealand Journal of Psychiatry*, *34*(3), 420-436.

Beck, a T., Kovacs, M., & Weissman, a. (1979). Assessment of suicidal intention: The scale for suicide ideation. Journal of Consulting and Clinical Psychology, 47(2), 343–352. https://doi.org/10.1037/0022-006X.47.2.343.

Beck, A. T. (1967). Depression: Clinical, experimental and theoretical aspects. New York: Harper and Row.

Botega, N. J., Barros, M. B. D. A., Oliveira, H. B. D., Dalgalarrondo, P., & Marín-León, L. (2005). Suicidal behavior in the community: prevalence and factors associated with suicidal ideation. *Brazilian Journal of Psychiatry*, *27*, 45-53.

Brooks, C., Sunkel, C., & Stewart, H. L. N. (2025). Dignity in mental healthcare: service user perspectives. Academia Mental Health and Well-Being, 2(1). https://doi.org/10.20935/MHealthWellB7523

Brown TA, Chorpita BF, Korotitsch W, Barlow DH. Psychometric properties of the Depression Anxiety Stress Scales (DASS) in clinical samples. Behav Res Ther. 1997 Jan;35(1):79-89. doi: 10.1016/s0005-7967(96)00068-x. PMID: 9009048.

Cha, C. B., Franz, P. J., M. Guzmán, E., Glenn, C. R., Kleiman, E. M., & Nock, M. K. (2018). Annual Research Review: Suicide among youth–epidemiology,(potential) etiology, and treatment. *Journal of Child Psychology and psychiatry*, *59*(4), 460-482.

Chu, C., Buchman-Schmitt, J. M., Stanley, I. H., Hom, M. A., Tucker, R. P., Hagan, C. R.,et al. (2017). The interpersonal theory of suicide: A systematic review and

metaanalysis of a decade of cross-national research. Psychological Bulletin. https://doi.org/10.1037/bul0000123.

Cohen, S., Kamarck, T., & Mermelstein, R. (1983). A global measure of perceived stress.Journal of Health and Social Behavior, 24(24), 386–396. https://doi.org/10.2307/2136404.

Connor, K. M., & Davidson, J. R. T. (2003). Development of a new resilience scale: The connor-davidson resilience scale (CD-RISC). Depression and Anxiety, 18(2), 76–82. https://doi.org/10.1002/da.10113.

Eagly, A. H., & Wood, W. (1999). The origins of sex differences in human behavior: Evolved dispositions versus social roles. American Psychologist, 54(6), 408–423. https://doi.org/10.1037/0003-066X.54.6.408

Felman. A & Sampson. S (2020), Why stress happens and how to manage it, Medical news today

Ferguson, C. J. (2021). One less reason why: Viewing of suicide-themed fictional media is associated with lower depressive symptoms in youth. *Mass Communication and Society*, *24*(1), 85-105.

Fleischmann, A., & De Leo, D. (2014). The World Health Organization's report on suicide: A fundamental step in worldwide suicide prevention [Editorial]. Crisis: The Journal of Crisis Intervention and Suicide Prevention, 35(5), 289–291. https://doi.org/10.1027/0227-5910/a000293

Folkman, S., & Moskowitz, J. T. (2000). Positive affect and the other side of coping. American Psychologist, 55, 647–654.

Garg, S., Chauhan, A., Singh, S., & Bansal, K. (2022). Epidemiological risk factors of suicidal behavior and effects of the components of coping strategies on suicidal behavior in medical students: An institution-based cross-sectional study in India. *Indian journal of psychiatry*, *64*(4), 377-386.

Gururaj, G., Isaac, M. K., Subbakrishna, D. K., & Ranjani, R. (2004). Risk factors for completed suicides: a case-control study from Bangalore, India. *Injury control and safety promotion*, *11*(3), 183-191.

Hyde et al. (2008) – Gender similarities in psychological traits Hyde, J. S., Lindberg, S. M., Linn, M. C., Ellis, A. B., & Williams, C. C. (2008).Gender similarities characterize math performance. Science, 321(5888), 494–495.

Hyde, J. S. (2005). The gender similarities hypothesis. American Psychologist, 60(6), 581–592.

Joiner, T. (2005). Why people die by suicide. Harvard University Press.

Joiner, T. (2005). Why People Die by Suicide. Harvard University Press. https://doi.org/10.2307/j.ctvjghv2f

Klonsky, E. D., & May, A. M. (2015). The Three-Step Theory (3ST): A new theory of suicide rooted in the "ideation-to-action" framework. International Journal of Cognitive Therapy, 8(2), 114–129. https://doi.org/10.1521/ijct.2015.8.2.114

Kothari, C. R. (2004). Research methodology: Methods and techniques (2nd ed.). New Age International Publishers.

Kumar, S., Verma, A. K., Bhattacharya, S., & Rathore, S. (2013). Trends in rates and methods of suicide in India. *Egyptian Journal of Forensic Sciences*, *3*(3), 75-80.

Kumar, V., & Talwar, R. (2014). Determinants of psychological stress and suicidal behavior in Indian adolescents: a literature review. *Journal of Indian Association for Child and Adolescent Mental Health*, *10*(1), 47-68.

Lazarus, R. S., & Folkman, S. (1984). Stress, appraisal, and coping. New York: Springer.

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. Behaviour research and therapy, 33(3), 335-343.

Lovibond, S.H. & Lovibond, P.F. (1995). Manual for the Depression Anxiety Stress Scales. (2nd. Ed.) Sydney: Psychology Foundation.

Manoranjitham, S. D., Rajkumar, A. P., Thangadurai, P., Prasad, J., Jayakaran, R., & Jacob, K. S. (2010). Risk factors for suicide in rural south India. *The British Journal of Psychiatry*, *196*(1), 26-30.

Menon, V., Kattimani, S., Shrivastava, M. K., & Thazath, H. K. (2013). Clinical and socio-demographic correlates of suicidal intent among young adults: A study from South India. *Crisis*.

Miranda-Mendizabal A, Castellví P, Parés-Badell O, Alayo I, Almenara J, Alonso I, Blasco MJ, Cebrià A, Gabilondo A, Gili M, Lagares C, Piqueras JA, Rodríguez-Jiménez T, Rodríguez-Marín J, Roca M, Soto-Sanz V, Vilagut G, Alonso J. Gender differences in suicidal behavior in adolescents and young adults: systematic review and meta-analysis of longitudinal studies. Int J Public Health. 2019 Mar;64(2):265-283. doi: 10.1007/s00038-018-1196-1. Epub 2019 Jan 12. PMID: 30635683; PMCID: PMC6439147.

Nath, Y., Paris, J., Thombs, B., & Kirmayer, L. (2012). Prevalence and social determinants of suicidal behaviours among college youth in India. *International Journal of Social Psychiatry*, *58*(4), 393-399.

National Crime Records Bureau (2908), Accidental Deaths and Suicides in India, Ministry of Home Affairs, Government of India.

Nock MK, Borges G, Bromet EJ, Alonso J, Angermeyer M, Beautrais A, Bruffaerts R, Chiu WT, de Girolamo G, Gluzman S, de Graaf R, Gureje O, Haro JM, Huang Y, Karam E, Kessler RC, Lepine JP, Levinson D, Medina-Mora ME, Ono Y, Posada-Villa J, Williams D. Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. Br J Psychiatry. 2008 Feb;192(2):98-105. doi: 10.1192/bjp.bp.107.040113. PMID: 18245022; PMCID: PMC2259024.

Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C., & Lee, S. (2008). Suicide and suicidal behavior. Epidemiologic Reviews, 30(1), 133–154. https://doi.org/10.1093/epirev/mxn002

Oxford University Press. (1989). Oxford English Dictionary (2nd ed.). Oxford University Press.

Pandey, M. K., & Kaur, C. (2009). Investigating suicidal trend and its economic determinants: evidence from India.

Parkar, S. R., Dawani, V., & Weiss, M. G. (2008). Gender, suicide, and the sociocultural context of deliberate self-harm in an urban general hospital in Mumbai, India. *Culture, Medicine, and Psychiatry*, *32*, 492-515.

Pascarella, E., & Terenzini, P. (2005). How college affects students: A third decade of research (Vol. 2). San Francisco: Jossey-Bass.

Patel, A., & Ghosh, S. (2020). Urban adolescent mental health in Mumbai: Exploring the role of digital media and academic stress. Journal of Youth Studies, 23(2), 193-206.

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. The Lancet, 369(9569), 1302–1313.

Pelkonen, M., & Marttunen, M. (2003). Child and adolescent suicide: epidemiology, risk factors, and approaches to prevention. *Pediatric Drugs*, *5*, 243-265.

Pillai, A., Andrews, T., & Patel, V. (2009). Violence, psychological distress and the risk of suicidal behaviour in young people in India. *International journal of epidemiology*, *38*(2), 459-469.

Portes, P.R., et al. (2002), Understanding adolescent suicide: a psychological interpretation of the developmental and contextual factors, Adolescence.

Posner K, Brown GK, Stanley B, Brent DA, Yershova KV, Oquendo MA, Currier GW, Melvin GA, Greenhill L, Shen S, Mann JJ. The Columbia-Suicide Severity Rating Scale: initial validity and internal consistency findings from three multisite studies with adolescents and adults. Am J Psychiatry. 2011 Dec;168(12):1266-77.

Prabha VS, Rao VB, Kanakabushanam GVVS. A comparative study of anxiety and depression among adolescents from rural and urban areas. J Med Sci Res. 2017; 5(1):29-32. DOI: http://dx.doi.org/10.17727/JMSR.2017/5-6

R Core Team (2024). *R: A Language and environment for statistical computing*. (Version 4.4) [Computer software]. Retrieved from https://cran.r-project.org. (R packages retrieved from CRAN snapshot 2024-08-07).

Rao, P., & Karanth, A. (2018). The gender paradox in adolescent mental health: Evidence from Karnataka. Indian Journal of Pediatrics, 85(7), 604-610.

Regenstrief Institute. (2023). LOINC® version 2.75. https://loinc.org

Roy, A., Sar chiapone, M Carli, V. (2007). Low Resilience in suicide Attempters: Relationship to depressive symptoms. Journal of Depression and Anxiety. 24: 273-274.

Russell, G., & Shaw, S. (2009). A study to investigate the prevalence of social anxiety in a sample of higher education students in the United Kingdom. Journal of Mental Health. 18(3), 198-206.

Sarkhel, S., Vijayakumar, V., & Vijayakumar, L. (2023). Clinical practice guidelines for management of suicidal behaviour. *Indian Journal of Psychiatry*, *65*(2), 124-130.

Shaikh BM, Doke PP, Gothankar JS. Depression, anxiety, stress, and stressors among rural adolescents studying in Pune and a rural block of Nanded district of Maharashtra, India. Indian J Public Health. 2018 Oct-Dec;62(4):311-314. doi: 10.4103/ijph.IJPH_174_17. PMID: 30539897.

Sharma, M. L., & Kumar, V. (2024). Multiple Factors Associated with Suicidal Ideation Among Indian Adults: A Review. *Journal of Advanced Zoology*, *45*(2).

Sharma, N., Gupta, S., & Sharma, N. (2016). Mental health among adolescents in urban Delhi: Gender differences and related social factors. Journal of Adolescent Health, 58(4), 372-378.

Sharma, R., & Sharma, P. (2015). A correlational study to assess the relation of anxiety and social phobia with academic performance of students in a selected nursing college. International Journal of Nursing Education, 7(2), 26-30.

Sidhartha, T., & Jena, S. (2006). Suicidal behaviors in adolescents. *The Indian Journal of Pediatrics*, *73*, 783-788.

Singh, A. K. (2006). Tests, measurements, and research methods in behavioural sciences (4th ed.). Bharti Bhawan Publishers.

Sonntag, H., Wittchen, H., Höfler, M., Kessler, R., & Stein, M. (2000). Are social fears and DSM-IV social anxiety disorder associated with smoking and nicotine dependence in adolescents and young adults? European Psychiatry, 15(1), 67–74.

Spielberger, C. D., Gorsuch, R. L., Lushene, R., Vagg, P. R., & Jacobs, G. A. (1983). Manual for the State-Trait Anxiety Inventory. Palo Alto, CA: Consulting Psychologists Press.

Srinivasan, K., & Sundararajan, V. (2019). Gender neutrality in suicidal ideation and behavior among youth in Chennai. Indian Journal of Social Psychiatry, 35(1), 50-57.

Taghavi, M. (2001). Study of validity and reliability of General Health Questionnaire. Journal of psychology, 20, 381-398. (Persian).

The jamovi project (2024). *jamovi*. (Version 2.6) [Computer Software]. Retrieved from https://www.jamovi.org.

Twenge & Nolen-Hoeksema (2002) – Trends in depression and anxiety, Twenge, J. M., & Nolen-Hoeksema, S. (2002).Age, gender, race, socioeconomic status, and birth cohort differences on the Children's Depression Inventory: A meta-analysis. Journal of Abnormal Psychology, 111(4), 578–588.

Twenge, J. M., Joiner, T. E., Rogers, M. L., & Martin, G. N. (2017). Increases in Depressive Symptoms, Suicide-Related Outcomes, and Suicide Rates Among U.S. Adolescents After 2010 and Links to Increased New Media Screen Time. Clinical Psychological Science, 6(1), 3-17. https://doi.org/10.1177/2167702617723376 (Original work published 2018)

Vijayakumar, L. (2010). Indian research on suicide. *Indian journal of psychiatry*, *52*(Suppl1), S291-S296.

Vijayakumar, L., Chandra, P. S., Kumar, M. S., Pathare, S., Banerjee, D., Goswami, T., & Dandona, R. (2022). The national suicide prevention strategy in India: context and considerations for urgent action. *The Lancet Psychiatry*, *9*(2), 160-168.

World Health Organization. (2014). Preventing suicide: A global imperative. https://www.who.int/publications/i/item/9789241564779

World Health Organization. (2019). International statistical classification of diseases and related health problems (10th rev.). https://icd.who.int/browse10/2019/en

# Chapter VI
# APPENDICES

## APPENDIX A

## PARTICIPANT CONSENT FORM

I [respondent's name] _____ hereby give my permission to Shrayasee Mitra (Researcher) to allow me to respond to a questionnaire and quote my responses in her research paper. I understand that their work is for academic purposes.

I also understand that I waive any claim for copyright to this material should the researchers ever publish it in a scholarly journal or in electronic format online.

I also understand that the researchers, hereby named SHRAYASEE MITRA, will maintain my anonymity with regard to my responses to Questionnaire items.

I hereby give my permission in the form of my signature below:

**Signature:**
**Date:**

Contacts of Researcher:
SHRAYASEE MITRA
EMAIL ID:mshrayasee03@gmail.com
CONTACT NO:7003133028

## APPENDIX B

SOCIODEMOGRAPHIC DETAILS

- Name :
- Gender :
- Age :
- Address :
- Marital Status:
- Mother Tongue:
- Education :
- Occupation:
- Religion :
- Residence:
- Family Type:
- Number of Family Members:
- Family Income:

**APPENDIX C**

# DASS21

Name: Date:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- ❑ Did not apply to me at all
- ❑ Applied to me to some degree, or some of the time
- ❑ Applied to me to a considerable degree or a good part of time
- ❑ Applied to me very much or most of the time

| | | | | | |
|---|---|---|---|---|---|
| 1 (s) | I found it hard to wind down | 0 | 1 | 2 | 3 |
| 2 (a) | I was aware of dryness of my mouth | 0 | 1 | 2 | 3 |
| 3 (d) | I couldn't seem to experience any positive feeling at all | 0 | 1 | 2 | 3 |
| 4 (a) | I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion) | 0 | 1 | 2 | 3 |
| 5 (d) | I found it difficult to work up the initiative to do things | 0 | 1 | 2 | 3 |
| 6 (s) | I tended to over-react to situations | 0 | 1 | 2 | 3 |
| 7 (a) | I experienced trembling (e.g. in the hands) | 0 | 1 | 2 | 3 |
| 8 (s) | I felt that I was using a lot of nervous energy | 0 | 1 | 2 | 3 |
| 9 (a) | I was worried about situations in which I might panic and make a fool of myself | 0 | 1 | 2 | 3 |
| 10 (d) | I felt that I had nothing to look forward to | 0 | 1 | 2 | 3 |
| 11 (s) | I found myself getting agitated | 0 | 1 | 2 | 3 |
| 12 (s) | I found it difficult to relax | 0 | 1 | 2 | 3 |
| 13 (d) | I felt down-hearted and blue | 0 | 1 | 2 | 3 |
| 14 (s) | I was intolerant of anything that kept me from getting on with what I was doing | 0 | 1 | 2 | 3 |
| 15 (a) | I felt I was close to panic | 0 | 1 | 2 | 3 |
| 16 (d) | I was unable to become enthusiastic about anything | 0 | 1 | 2 | 3 |
| 17 (d) | I felt I wasn't worth much as a person | 0 | 1 | 2 | 3 |
| 18 (s) | I felt that I was rather touchy | 0 | 1 | 2 | 3 |
| 19 (a) | I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat) | 0 | 1 | 2 | 3 |
| 20 (a) | I felt scared without any good reason | 0 | 1 | 2 | 3 |
| 21 (d) | I felt that life was meaningless | 0 | 1 | 2 | 3 |

**APPENDIX D**

# COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Pediatric - Since Last Contact – Communities and Healthcare

Version 6/23/10

***Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.***

Disclaimer:

This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Definitions of behavioral suicidal events in this scale are based on those used in **The Columbia Suicide History Form**, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M. A., Halberstam B. & Mann J. J., Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First [Ed.] Standardized Evaluation in Clinical Practice, pp. 103 -130, 2003.)

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032; inquiries and training requirements contact *posnerk@nyspi.columbia.edu*

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## *SUICIDAL IDEATION*

*Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.*

**Since Last Visit**

**1. Wish to be Dead**

Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

***Have you thought about being dead or what it would be like to be dead?***

***Have you wished you were dead or wished you could go to sleep and never wake up?***

***Do you wish you weren't alive anymore?***

If yes, describe:

**Yes** ☐ **No** ☐

**2. Non-Specific Active Suicidal Thoughts**

General, non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself*") without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.

***Have you thought about doing something to make yourself not alive anymore?***

***Have you had any thoughts about killing yourself?***

If yes, describe:

**Yes** ☐ **No** ☐

**3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act**

Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."*

***Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)?***

***What did you think about?***

If yes, describe:

**Yes** ☐ **No** ☐

**4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan**

Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."*

***When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do? This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.***

If yes, describe:

**Yes** ☐ **No** ☐

**5. Active Suicidal Ideation with Specific Plan and Intent**

Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out.

***Have you decided how or when you would make yourself not alive anymore/kill yourself? Have you planned out (worked out the details of) how you would do it?***

***What was your plan?***

***When you made this plan (or worked out these details), was any part of you thinking about actually doing it?***

If yes, describe:

**Yes** ☐ **No** ☐

## *INTENSITY OF IDEATION*

*The following feature should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe).*

***Most Severe Ideation:*** _____ _____

***Type # (1-5)*** ***Description of Ideation***

Most Severe ____

**Frequency**

***How many times have you had these thoughts?*** ***Write response*** _____

(1) Only one time (2) A few times (3) A lot (4) All the time (0) Don't know/Not applicable

____

| ***SUICIDAL BEHAVIOR***<br>*(Check all that apply, so long as these are separate events; must ask about all types)* | **Since Last Visit** |
|---|---|
| **Actual Attempt:**<br>A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt.<br>Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.<br>***Did you <u>do anything</u> to try to kill yourself or make yourself not alive anymore?***<br>***What did you do?***<br>***Did you hurt yourself on purpose? Why did you do that?***<br>***Did you_____ as a way to end your life?***<br>***Did you want to die (even a little) when you____?***<br>***Were you trying to make yourself not alive anymore when you _____? Or did you think it was possible you cou***<br>***Or did you do it purely for other reasons, <u>not at all</u> to end your life or kill yourself (like to make yourself feel better, or get something else to happen)?*** *(*Self-Injurious Behavior without suicidal intent) | **Yes No**<br>☐ ☐<br><br>Total # of Attempts<br>_____ |
| If yes, describe:<br><br>**Has subject engaged in Non-Suicidal Self-Injurious**<br><br>**Behavior?**<br><br>**Has subject engaged in Self-Injurious Behavior,**<br><br>**intent unknown?** | **Yes No**<br>☐ ☐<br>**Yes No**<br>☐ ☐ |
| **Interrupted Attempt:**<br>When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).*<br>Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather thanan interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so.<br>***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?***<br>If yes, describe: | **Yes No**<br>☐ ☐<br><br>Total # of Interrupted<br>_____ |
| **Aborted Attempt or Self-Interrupted Attempt:**<br>When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.<br>***Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything? What did you do?***<br>If yes, describe: | **Yes No**<br>☐ ☐<br>Total # of aborted or self-interrupted<br>_____ |
| **Preparatory Acts or Behavior:**<br>Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).<br>***Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?***<br>If yes, describe: | **Yes No**<br>☐ ☐<br>Total # of preparatory acts<br>_____ |
| **Suicide:**<br>Death by suicide occurred since last assessment. | **Yes No**<br>☐ ☐ |
| | Most Lethal Attempt<br><br>Date: |

| | |
|---|---|
| **Actual Lethality/Medical Damage:**<br>0. No physical damage or very minor physical damage (e.g., surface scratches).<br>1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains).<br>2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel).<br>3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures).<br>4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area).<br>5. Death | *Enter Code*<br>_____ |
| **Potential Lethality: Only Answer if Actual Lethality=0**<br>Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over).<br>0 = Behavior not likely to result in injury<br>1 = Behavior likely to result in injury but not likely to cause death<br>2 = Behavior likely to result in death despite available medical care | *Enter Code*<br>_____ |